

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: 14-0046	Period: From 01/01/2023 To 12/31/2023	Worksheet S Parts I-III Date/Time Prepared: 5/21/2024 10:06 am
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PART I - COST REPORT STATUS

Provider use only	1. <input checked="" type="checkbox"/> Electronically prepared cost report 2. <input type="checkbox"/> Manually prepared cost report 3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report 4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no.	Date: 5/21/2024 Time: 10:06 am
Contractor use only	5. <input type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended 6. Date Received: 7. Contractor No. 8. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN 10. NPR Date: 11. Contractor's Vendor Code: 4 12. <input type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.	

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

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by SSM HEALTH GOOD SAMARITAN HOSPITAL (14-0046) for the cost reporting period beginning 01/01/2023 and ending 12/31/2023 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

	SIGNATURE OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR	CHECKBOX	ELECTRONIC SIGNATURE STATEMENT	
	1	2		
1	Eileen Lamm	Y	I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name	Eileen Lamm		2
3	Signatory Title	REGIONAL VP FINANCE		3
4	Date	(Dated when report is electronic)		4

	Title V	Title XVIII		HIT	Title XIX	
		Part A	Part B			
	1.00	2.00	3.00	4.00	5.00	
PART III - SETTLEMENT SUMMARY						
1.00	HOSPITAL	0	-14,907	-172,732	0	1.00
2.00	SUBPROVIDER - IPF	0	0	0	0	2.00
3.00	SUBPROVIDER - IRF	0	976,624	0	0	3.00
5.00	SWING BED - SNF	0	0	0	0	5.00
6.00	SWING BED - NF	0			0	6.00
200.00	TOTAL	0	961,717	-172,732	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: 14-0046		Period: From 01/01/2023 To 12/31/2023		Worksheet S-2 Part I Date/Time Prepared: 5/21/2024 10:06 am			
1.00		2.00		3.00		4.00					
Hospital and Hospital Health Care Complex Address:											
1.00	Street: 1 GOOD SAMARITAN WAY			PO Box:				1.00			
2.00	City: MT. VERNON			State: IL		Zip Code: 62864		County: JEFFERSON			
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)			
								V	XVIII	XIX	
		1.00		2.00	3.00	4.00	5.00	6.00	7.00	8.00	
Hospital and Hospital-Based Component Identification:											
3.00	Hospital			SSM HEALTH GOOD SAMARITAN HOSPITAL	140046	99914	1	07/01/1966	N	P	P
4.00	Subprovider - IPF										
5.00	Subprovider - IRF			GOOD SAMARITAN REHABILITATION UNIT	14T046	99914	5	01/01/1990	N	P	P
6.00	Subprovider - (Other)										
7.00	Swing Beds - SNF										
8.00	Swing Beds - NF										
9.00	Hospital-Based SNF										
10.00	Hospital-Based NF										
11.00	Hospital-Based OLTC										
12.00	Hospital-Based HHA										
13.00	Separately Certified ASC										
14.00	Hospital-Based Hospice										
15.00	Hospital-Based Health Clinic - RHC										
16.00	Hospital-Based Health Clinic - FQHC										
17.00	Hospital-Based (CMHC) I										
18.00	Renal Dialysis										
19.00	Other										
							From:	To:			
							1.00	2.00			
20.00	Cost Reporting Period (mm/dd/yyyy)						01/01/2023		12/31/2023		20.00
21.00	Type of Control (see instructions)						1				21.00
						1.00	2.00	3.00			
Inpatient PPS Information											
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2) (Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					Y	N				22.00
22.01	Did this hospital receive interim UCPs, including supplemental UCPs, for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					Y	Y				22.01
22.02	Is this a newly merged hospital that requires a final UCP to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N				22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					N	N		N		22.03
22.04	Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.										22.04
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					3	N				23.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0046		Period: From 01/01/2023 To 12/31/2023		Worksheet S-2 Part I Date/Time Prepared: 5/21/2024 10:06 am			
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of- State Medicaid paid days	Out-of- State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days		
		1.00	2.00	3.00	4.00	5.00	6.00		
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	703	707	7	21	5,478	74	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.	22	100	0	0	93		25.00	
						Urban/Rural	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.	Y	Y		60.00	
60.01	If line 60 is yes, complete columns 2 and 3 for each program. (see instructions)		23.00	1	60.01	
		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: 14-0046

Period:
From 01/01/2023
To 12/31/2023Worksheet S-2
Part I
Date/Time Prepared:
5/21/2024 10:06 am

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

Health Financial Systems		SSM HEALTH GOOD SAMARI TAN HOSPITAL		In Lieu of Form CMS-2552-10		
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0046	Period: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part I Date/Time Prepared: 5/21/2024 10:06 am		
			1.00			
68.00	Direct GME in Accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-49072 (August 10, 2022) For a cost reporting period beginning prior to October 1, 2022, did you obtain permission from your MAC to apply the new DGME formula in accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-49072 (August 10, 2022)?			68.00		
			1.00	2.00	3.00	
Inpatient Psychiatric Facility PPS						
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.			N	70.00	
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	71.00	
Inpatient Rehabilitation Facility PPS						
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.			Y	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

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		V 1.00		XIX 2.00			
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y		Y		98.00	
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y		Y		98.01	
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y		Y		98.02	
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N		N		98.03	
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N		N		98.04	
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y		Y		98.05	
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y		Y		98.06	
Rural Providers							
105.00	Does this hospital qualify as a CAH?	N				105.00	
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)					106.00	
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)					107.00	
107.01	If this facility is a REH (line 3, column 4, is "12"), is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no. (see instructions)					107.01	
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N				108.00	
		Physical 1.00	Occupational 2.00	Speech 3.00	Respiratory 4.00		
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	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			
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			
112.00	Did this hospital participate in the Pennsylvania Rural Health Model (PARHM) demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N				112.00	
Miscellaneous Cost Reporting Information							
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N				0115.00	
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	Y				116.00	
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y				117.00	
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1				118.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0046	Period: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part I Date/Time Prepared: 5/21/2024 10:06 am
		Premiums	Losses	Insurance
		1.00	2.00	3.00
118.01	List amounts of malpractice premiums and paid losses:	3,457,441	0	0
		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	N	123.00
Certified Transplant Center Information				
125.00	Does this facility operate a Medicare-certified transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare-certified kidney transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare-certified heart transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare-certified liver transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare-certified lung transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare-certified pancreas transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare-certified intestinal transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare-certified islet transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	Removed and reserved			133.00
134.00	If this is a hospital-based organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
All Providers				
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	HB1798	140.00
		1.00	2.00	3.00
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.				
141.00	Name: SSM HEALTH CARE CORPORATION	Contractor's Name: WPS	Contractor's Number: 05301	141.00
142.00	Street: 12800 CORPORATE HILL DRIVE	PO Box:		142.00
143.00	City: ST. LOUIS	State: MO	Zip Code: 63131	143.00
				1.00
144.00	Are provider based physicians' costs included in Worksheet A?		Y	144.00
		1.00	2.00	
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.	Y		145.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N		146.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0046		Period: From 01/01/2023 To 12/31/2023		Worksheet S-2 Part I Date/Time Prepared: 5/21/2024 10:06 am		
						1.00		
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.						N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.						N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.						N	149.00
		Part A	Part B	Title V	Title XIX			
		1.00	2.00	3.00	4.00			
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)								
155.00	Hospital	N	N	N	N		155.00	
156.00	Subprovider - IPF	N	N	N	N		156.00	
157.00	Subprovider - IRF	N	N	N	N		157.00	
158.00	SUBPROVIDER						158.00	
159.00	SNF	N	N	N	N		159.00	
160.00	HOME HEALTH AGENCY	N	N	N	N		160.00	
161.00	CMHC		N	N	N		161.00	
						1.00		
Multicampus								
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.						N	165.00
		Name	County	State	Zip Code	CBSA	FTE/Campus	
		0	1.00	2.00	3.00	4.00	5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00	
						1.00		
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act								
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.						Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)							168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)							168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)						0.00	169.00
				Beginning	Ending			
				1.00	2.00			
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)							170.00
				1.00	2.00			
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)						N	0171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0046		Period: From 01/01/2023 To 12/31/2023		Worksheet S-2 Part II Date/Time Prepared: 5/21/2024 10:06 am	
				Y/N	Date		
				1.00	2.00		
PART II - HOSPITAL AND HOSPITAL HEALTHCARE COMPLEX REIMBURSEMENT QUESTIONNAIRE							
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.							
COMPLETED BY ALL HOSPITALS							
Provider Organization and Operation							
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N					1.00
		Y/N	Date	V/I			
		1.00	2.00	3.00			
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N					2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y					3.00
		Y/N	Type	Date			
		1.00	2.00	3.00			
Financial Data and Reports							
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A				4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	Y					5.00
				Y/N	Legal Oper.		
				1.00	2.00		
Approved Educational Activities							
6.00	Column 1: Are costs claimed for a nursing program? Column 2: If yes, is the provider the legal operator of the program?	N					6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N					7.00
8.00	Were nursing programs and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N					8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N					9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N					10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N					11.00
				Y/N			
				1.00			
Bad Debts							
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y			12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N			13.00
14.00	If line 12 is yes, were patient deductibles and/or coinsurance amounts waived? If yes, see instructions.			N			14.00
Bed Complement							
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N			15.00
		Part A		Part B			
		Y/N	Date	Y/N	Date		
		1.00	2.00	3.00	4.00		
PS&R Data							
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		N			16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	03/29/2024	Y	03/29/2024		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N			18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N			19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-0046

Period:
From 01/01/2023
To 12/31/2023Worksheet S-2
Part II
Date/Time Prepared:
5/21/2024 10:06 am

		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions				22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				33.00
Provider-Based Physicians					
34.00	Were services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				35.00
		Y/N	Date		
		1.00	2.00		
Home Office Costs					
36.00	Were home office costs claimed on the cost report?		Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.		Y		37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.		N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.		Y		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.		N		40.00
		1.00	2.00		
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	JENNIFER	COHEN		41.00
42.00	Enter the employer/company name of the cost report preparer.	SSM HEALTH			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	314-989-3939	JENNIFER.COHEN@SSMHEALTH.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

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		3.00	
Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	REGIONAL DIRECTOR GOVERNMENT REIMBUR	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: 14-0046

Period:
From 01/01/2023
To 12/31/2023Worksheet S-3
Part I
Date/Time Prepared:
5/21/2024 10:06 am

Component	Worksheet A	No. of Beds	Bed Days Available	CAH/REH Hours	I/P Days / O/P	
	Line No.				Visits / Trips	
	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	95	34,675	0.00	0	1.00
2.00 HMO and other (see instructions)						2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00 Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		95	34,675	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	16	5,840	0.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		111	40,515	0.00	0	14.00
15.00 CAH visits					0	15.00
15.10 REH hours and visits				0.00	0	15.10
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	41.00	10	3,650		0	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)		121			0	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)		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: 14-0046

Period:
From 01/01/2023
To 12/31/2023Worksheet S-3
Part I
Date/Time Prepared:
5/21/2024 10:06 am

Component		I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	11,378	306	25,208			1.00
2.00	HMO and other (see instructions)	4,927	5,022				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	79	280				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	11,378	306	25,208			7.00
8.00	INTENSIVE CARE UNIT	1,069	37	2,551			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		1,551	2,093			13.00
14.00	Total (see instructions)	12,447	1,894	29,852	0.00	747.50	14.00
15.00	CAH visits	0	0	0			15.00
15.10	REH hours and visits	0	0	0			15.10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	1,236	22	2,360	0.00	20.14	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	767.64	27.00
28.00	Observation Bed Days		585	1,012			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			208			30.00
31.00	Employee discount days - IRF			87			31.00
32.00	Labor & delivery days (see instructions)	0	74	578			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: 14-0046

Period:
From 01/01/2023
To 12/31/2023Worksheet S-3
Part I
Date/Time Prepared:
5/21/2024 10:06 am

Component	Full Time Equivalents	Discharges			Total All Patients	
	Nonpaid Workers	Title V	Title XVIII	Title XIX		
	11.00	12.00	13.00	14.00	15.00	
PART I - STATISTICAL DATA						
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	2,714	123	11,081	1.00
2.00 HMO and other (see instructions)			1,032	1,791		2.00
3.00 HMO IPF Subprovider				0		3.00
4.00 HMO IRF Subprovider				16		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	2,714	123	11,081	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	0.00	0	104	2	198	17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days			0			33.00
33.01 LTCH site neutral days and discharges			0			33.01
34.00 Temporary Expansion COVID-19 PHE Acute Care						34.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0046

Period:
From 01/01/2023
To 12/31/2023Worksheet S-3
Part II
Date/Time Prepared:
5/21/2024 10:06 am

	Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART II - WAGE DATA							
SALARIES							
1.00	Total salaries (see instructions)	200.00	63,241,959	0	63,241,959	1,550,961.92	40.78
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00
5.00	Physician and Non Physician-Part B		0	0	0	0.00	0.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00
8.00	Home office and/or related organization personnel		1,536,114	0	1,536,114	12,100.22	126.95
9.00	SNF	44.00	0	0	0	0.00	0.00
10.00	Excluded area salaries (see instructions)		2,820,211	0	2,820,211	60,561.83	46.57
OTHER WAGES & RELATED COSTS							
11.00	Contract Labor: Direct Patient Care		6,608,956	0	6,608,956	59,863.26	110.40
12.00	Contract Labor: Top level management and other management and administrative services		0	0	0	0.00	0.00
13.00	Contract Labor: Physician-Part A - Administrative		484,596	0	484,596	1,221.75	396.64
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00
14.01	Home office salaries		9,815,077	0	9,815,077	160,307.90	61.23
14.02	Related organization salaries		0	0	0	0.00	0.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00
16.01	Home office Physicians Part A - Teaching		0	0	0	0.00	0.00
16.02	Home office contract Physicians Part A - Teaching		0	0	0	0.00	0.00
WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		37,645,500	0	37,645,500		
18.00	Wage-related costs (other) (see instructions)						
19.00	Excluded areas		1,529,710	0	1,529,710		
20.00	Non-physician anesthetist Part A		0	0	0		
21.00	Non-physician anesthetist Part B		0	0	0		
22.00	Physician Part A - Administrative		0	0	0		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		0	0	0		
24.00	Wage-related costs (RHC/FQHC)		0	0	0		
25.00	Interns & residents (in an approved program)		0	0	0		
25.50	Home office wage-related (core)		3,475,648	0	3,475,648		
25.51	Related organization wage-related (core)		0	0	0		
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0		

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0046

Period:
From 01/01/2023
To 12/31/2023Worksheet S-3
Part II
Date/Time Prepared:
5/21/2024 10:06 am

		Wkst. A Line Number	Amount Reported	Reclassifi- cation of Salaries (from Wkst. A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
25.53	Home office: Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53
OVERHEAD COSTS - DIRECT SALARIES								
26.00	Employee Benefits Department	4.00	389,178	0	389,178	18,544.53	20.99	26.00
27.00	Administrative & General	5.00	3,959,813	0	3,959,813	95,525.11	41.45	27.00
28.00	Administrative & General under contract (see inst.)		1,251,571	0	1,251,571	5,811.61	215.36	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	1,062,801	0	1,062,801	38,165.48	27.85	30.00
31.00	Laundry & Linen Service	8.00	94,961	0	94,961	5,231.26	18.15	31.00
32.00	Housekeeping	9.00	1,653,390	0	1,653,390	85,963.53	19.23	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	834,192	-567,444	266,748	14,350.83	18.59	34.00
35.00	Dietary under contract (see instructions)		181,955	0	181,955	5,760.00	31.59	35.00
36.00	Cafeteria	11.00	0	567,444	567,444	0.00	0.00	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	930,174	0	930,174	21,179.40	43.92	38.00
39.00	Central Services and Supply	14.00	439,155	0	439,155	20,850.76	21.06	39.00
40.00	Pharmacy	15.00	2,194,676	0	2,194,676	46,439.04	47.26	40.00
41.00	Medical Records & Medical Records Library	16.00	0	0	0	0.00	0.00	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0046

Period:
From 01/01/2023
To 12/31/2023Worksheet S-3
Part III
Date/Time Prepared:
5/21/2024 10:06 am

	Worksheet A Line Number	Amount Reported	Recl assi fi cati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col . 2 ± col . 3)	Paid Hours Related to Salaries in col . 4	Average Hourly Wage (col . 4 ÷ col . 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	63,139,371	0	63,139,371	1,550,433.31	40.72	1.00
2.00	Excluded area salaries (see instructions)	2,820,211	0	2,820,211	60,561.83	46.57	2.00
3.00	Subtotal salaries (line 1 minus line 2)	60,319,160	0	60,319,160	1,489,871.48	40.49	3.00
4.00	Subtotal other wages & related costs (see inst.)	16,908,629	0	16,908,629	221,392.91	76.37	4.00
5.00	Subtotal wage-related costs (see inst.)	41,121,148	0	41,121,148	0.00	68.17	5.00
6.00	Total (sum of lines 3 thru 5)	118,348,937	0	118,348,937	1,711,264.39	69.16	6.00
7.00	Total overhead cost (see instructions)	12,991,866	0	12,991,866	357,821.55	36.31	7.00

HOSPITAL WAGE RELATED COSTS

Provider CCN: 14-0046

Period:
From 01/01/2023
To 12/31/2023Worksheet S-3
Part IV
Date/Time Prepared:
5/21/2024 10:06 am

		Amount Reported	
		1.00	
PART IV - WAGE RELATED COSTS			
Part A - Core List			
RETIREMENT COST			
1.00	401K Employer Contributions	0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	1,305,762	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)			
5.00	401K/TSA Plan Administration fees	1,965,469	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
HEALTH AND INSURANCE COST			
8.00	Health Insurance (Purchased or Self Funded)	0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	25,473,396	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	0	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	3,411,070	9.00
10.00	Dental, Hearing and Vision Plan	1,117,465	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	58,589	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	10,527	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	4,691	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	748,445	14.00
15.00	'Workers' Compensation Insurance	0	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Noncumulative portion)	0	16.00
TAXES			
17.00	FICA-Employers Portion Only	4,657,139	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	263,563	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
OTHER			
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	159,094	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	39,175,210	24.00
Part B - Other than Core Related Cost			
25.00	OTHER WAGE RELATED COSTS (SPECIFY)		25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST

Provider CCN: 14-0046

Period:
From 01/01/2023
To 12/31/2023Worksheet S-3
Part V
Date/Time Prepared:
5/21/2024 10:06 am

Cost Center Description		Contract Labor	Benefit Cost	
		1.00	2.00	
PART V - Contract Labor and Benefit Cost				
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost	6,608,956	39,175,211	1.00
2.00	Hospital	6,608,956	37,645,500	2.00
3.00	SUBPROVIDER - IPF			3.00
4.00	SUBPROVIDER - IRF	0	1,049,043	4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	SKILLED NURSING FACILITY			8.00
9.00	NURSING FACILITY			9.00
10.00	OTHER LONG TERM CARE I			10.00
11.00	Hospital-Based HHA			11.00
12.00	AMBULATORY SURGICAL CENTER (D.P.) I			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	RENAL DIALYSIS I	0	0	17.00
18.00	Other	0	480,668	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA

Provider CCN: 14-0046

Period:
From 01/01/2023
To 12/31/2023Worksheet S-10
Parts I & II
Date/Time Prepared:
5/21/2024 10:06 am

			1.00	
PART I - HOSPITAL AND HOSPITAL COMPLEX DATA				
Uncompensated and Indigent Care Cost-to-Charge Ratio				
1.00	Cost to charge ratio (see instructions)		0.238919	1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid		17,452,642	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		N	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?			4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid		0	5.00
6.00	Medicaid charges		153,416,378	6.00
7.00	Medicaid cost (line 1 times line 6)		36,654,088	7.00
8.00	Difference between net revenue and costs for Medicaid program (see instructions)		19,201,446	8.00
Children's Health Insurance Program (CHIP) (see instructions for each line)				
9.00	Net revenue from stand-alone CHIP		0	9.00
10.00	Stand-alone CHIP charges		0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)		0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (see instructions)		0	12.00
Other state or local government indigent care program (see instructions for each line)				
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)		0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)		0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (see instructions)		0	16.00
Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)				
17.00	Private grants, donations, or endowment income restricted to funding charity care		0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations		0	18.00
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		19,201,446	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)	8,844,942	766,426	9,611,368
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	2,113,225	766,426	2,879,651
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0
23.00	Cost of charity care (see instructions)	2,113,225	766,426	2,879,651
			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)		6,140,691	26.00
27.00	Medicare reimbursable bad debts (see instructions)		818,496	27.00
27.01	Medicare allowable bad debts (see instructions)		1,259,225	27.01
28.00	Non-Medicare bad debt amount (see instructions)		4,881,466	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)		1,607,004	29.00
30.00	Cost of uncompensated care (line 23, col. 3, plus line 29)		4,486,655	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		23,688,101	31.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA

Provider CCN: 14-0046

Period:
From 01/01/2023
To 12/31/2023Worksheet S-10
Parts I & II
Date/Time Prepared:
5/21/2024 10:06 am

			1.00	
PART II - HOSPITAL DATA				
Uncompensated and Indigent Care Cost-to-Charge Ratio				
1.00	Cost to charge ratio (see instructions)		0.233592	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)	8,804,019	763,726	9,567,745
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	2,056,548	763,726	2,820,274
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0
23.00	Cost of charity care (see instructions)	2,056,548	763,726	2,820,274
			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
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit			0
25.01	Charges for insured patients' liability (see instructions)			0
26.00	Bad debt amount (see instructions)			6,138,378
27.00	Medicare reimbursable bad debts (see instructions)			817,456
27.01	Medicare allowable bad debts (see instructions)			1,257,625
28.00	Non-Medicare bad debt amount (see instructions)			4,880,753
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)			1,580,274
30.00	Cost of uncompensated care (line 23, col. 3, plus line 29)			4,400,548
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			4,400,548

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0046

Period:
From 01/01/2023
To 12/31/2023

Worksheet A

Date/Time Prepared:
5/21/2024 10:06 am

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassification (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)	
			1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT		6,824,401	6,824,401	0	6,824,401	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		4,536,235	4,536,235	0	4,536,235	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	389,178	22,282,486	22,671,664	-2,121	22,669,543	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,959,813	44,607,454	48,567,267	1,211,337	49,778,604	5.00
7.00	00700	OPERATION OF PLANT	1,062,801	5,036,773	6,099,574	250,579	6,350,153	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	94,961	585,397	680,358	-7,091	673,267	8.00
9.00	00900	HOUSEKEEPING	1,653,390	691,742	2,345,132	-46,117	2,299,015	9.00
10.00	01000	DIETARY	834,192	1,683,639	2,517,831	-1,712,946	804,885	10.00
11.00	01100	CAFETERIA	0	0	0	1,712,707	1,712,707	11.00
13.00	01300	NURSING ADMINISTRATION	930,174	1,137,548	2,067,722	-2,772	2,064,950	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	439,155	215,844	654,999	-265,252	389,747	14.00
15.00	01500	PHARMACY	2,194,676	11,985,192	14,179,868	-11,525,371	2,654,497	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	27,956	27,956	0	27,956	16.00
17.00	01700	SOCIAL SERVICE	0	2,150	2,150	-5	2,145	17.00
23.00	02300	PARAMED ED PRGM-LABARATORY ED	0	71	71	0	71	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	17,149,864	4,840,994	21,990,858	236,403	22,227,261	30.00
31.00	03100	INTENSIVE CARE UNIT	2,741,389	1,777,201	4,518,590	-869,102	3,649,488	31.00
41.00	04100	SUBPROVIDER - I RF	1,693,508	837,633	2,531,141	-32,248	2,498,893	41.00
43.00	04300	NURSERY	543,705	0	543,705	542,471	1,086,176	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,471,114	9,826,912	12,298,026	-7,411,677	4,886,349	50.00
51.00	05100	RECOVERY ROOM	932,493	242,041	1,174,534	-226,618	947,916	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,805,333	1,029,557	4,834,890	-1,638,734	3,196,156	52.00
53.00	05300	ANESTHESIOLOGY	41,877	6,106,228	6,148,105	-285,762	5,862,343	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,727,545	182,984	1,910,529	-92,967	1,817,562	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	1,316,555	691,095	2,007,650	-187,290	1,820,360	55.00
56.00	05600	RADIOISOTOPE	185,088	468,158	653,246	-11,564	641,682	56.00
57.00	05700	CT SCAN	583,578	599,590	1,183,168	-71,418	1,111,750	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	240,924	124,498	365,422	-20,055	345,367	58.00
59.00	05900	CARDIAC CATHETERIZATION	933,559	3,140,619	4,074,178	-2,598,903	1,475,275	59.00
60.00	06000	LABORATORY	2,498,520	4,025,235	6,523,755	-2,197,030	4,326,725	60.00
64.00	06400	INTRAVENOUS THERAPY	219,219	18,051	237,270	-13,664	223,606	64.00
65.00	06500	RESPIRATORY THERAPY	1,782,990	620,608	2,403,598	-223,715	2,179,883	65.00
66.00	06600	PHYSICAL THERAPY	1,043,156	186,529	1,229,685	-10,335	1,219,350	66.00
66.01	03951	CLINICAL NUTRITION	156,247	307	156,554	0	156,554	66.01
67.00	06700	OCCUPATIONAL THERAPY	511,418	47,972	559,390	-4,783	554,607	67.00
68.00	06800	SPEECH PATHOLOGY	327,596	6,123	333,719	-755	332,964	68.00
69.00	06900	ELECTROCARDIOLOGY	2,008,707	1,021,294	3,030,001	-170,796	2,859,205	69.00
69.01	06901	CARDIAC REHABILITATION	134,314	618	134,932	-2,819	132,113	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	29,765	12,484	42,249	-566	41,683	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	12,095,453	12,095,453	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	4,527,763	4,527,763	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,180,338	188,095	1,368,433	11,368,750	12,737,183	73.00
74.00	07400	RENAL DIALYSIS	0	1,011,189	1,011,189	-11,932	999,257	74.00
76.00	03950	ENDOSCOPY	0	0	0	0	0	76.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	3,606,180	2,090,347	5,696,527	-330,710	5,365,817	90.00
91.00	09100	EMERGENCY	2,691,934	2,391,551	5,083,485	-496,378	4,587,107	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	62,115,256	141,104,801	203,220,057	1,473,967	204,694,024	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	40,220	4	40,224	0	40,224	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	-357,468	-357,468	0	-357,468	192.00
194.00	07950	OTHER NRB COST CENTER	657,123	1,991,510	2,648,633	-1,473,967	1,174,666	194.00
194.01	07951	OTHER NRB COST CENTER	0	0	0	0	0	194.01
194.02	07952	NONREIMBURSABLE COST CENTER	0	0	0	0	0	194.02
194.03	07953	RETAIL PHARMACY	429,360	7,703,779	8,133,139	0	8,133,139	194.03
200.00		TOTAL (SUM OF LINES 118 through 199)	63,241,959	150,442,626	213,684,585	0	213,684,585	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0046

Period:
From 01/01/2023
To 12/31/2023

Worksheet A

Date/Time Prepared:
5/21/2024 10:06 am

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	-500,963	6,323,438	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	64,045	4,600,280	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	6,698,338	29,367,881	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-16,898,664	32,879,940	5.00
7.00	00700	OPERATION OF PLANT	-78,305	6,271,848	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	673,267	8.00
9.00	00900	HOUSEKEEPING	-2,434	2,296,581	9.00
10.00	01000	DIETARY	0	804,885	10.00
11.00	01100	CAFETERIA	-642,662	1,070,045	11.00
13.00	01300	NURSING ADMINISTRATION	-319,692	1,745,258	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-38,348	351,399	14.00
15.00	01500	PHARMACY	-67,079	2,587,418	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-1,688	26,268	16.00
17.00	01700	SOCIAL SERVICE	0	2,145	17.00
23.00	02300	PARAMED ED PRGM-LABORATORY ED	0	71	23.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-5,911,330	16,315,931	30.00
31.00	03100	INTENSIVE CARE UNIT	-1,158,517	2,490,971	31.00
41.00	04100	SUBPROVIDER - IIRF	-169,033	2,329,860	41.00
43.00	04300	NURSERY	0	1,086,176	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-313,813	4,572,536	50.00
51.00	05100	RECOVERY ROOM	0	947,916	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	-3,681	3,192,475	52.00
53.00	05300	ANESTHESIOLOGY	-5,645,519	216,824	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-2,672	1,814,890	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	-278,060	1,542,300	55.00
56.00	05600	RADIOISOTOPE	-148	641,534	56.00
57.00	05700	CT SCAN	-302,037	809,713	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	345,367	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	1,475,275	59.00
60.00	06000	LABORATORY	-339,285	3,987,440	60.00
64.00	06400	INTRAVENOUS THERAPY	0	223,606	64.00
65.00	06500	RESPIRATORY THERAPY	-8,445	2,171,438	65.00
66.00	06600	PHYSICAL THERAPY	-150	1,219,200	66.00
66.01	03951	CLINICAL NUTRITION	0	156,554	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	554,607	67.00
68.00	06800	SPEECH PATHOLOGY	0	332,964	68.00
69.00	06900	ELECTROCARDIOLOGY	-362,474	2,496,731	69.00
69.01	06901	CARDIAC REHABILITATION	19,366	151,479	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	-5,762	35,921	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	-1,543,259	10,552,194	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	4,527,763	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	12,737,183	73.00
74.00	07400	RENAL DIALYSIS	-22,443	976,814	74.00
76.00	03950	ENDOSCOPY	0	0	76.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	78.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	-80,261	5,285,556	90.00
91.00	09100	EMERGENCY	-915,551	3,671,556	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
OTHER REIMBURSABLE COST CENTERS					
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	102.00
SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-28,830,526	175,863,498	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	40,224	190.00
191.00	19100	RESEARCH	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	-357,468	192.00
194.00	07950	OTHER NRB COST CENTER	-936,658	238,008	194.00
194.01	07951	OTHER NRB COST CENTER	0	0	194.01
194.02	07952	NONREIMBURSABLE COST CENTER	0	0	194.02
194.03	07953	RETAIL PHARMACY	0	8,133,139	194.03
200.00		TOTAL (SUM OF LINES 118 through 199)	-29,767,184	183,917,401	200.00

RECLASSIFICATIONS

Provider CCN: 14-0046

Period:
From 01/01/2023
To 12/31/2023

Worksheet A-6

Date/Time Prepared:
5/21/2024 10:06 am

Increases						
Cost Center	Line #	Salary	Other			
2.00	3.00	4.00	5.00			
	A - DRUG SUPPLY IMPLANT IV AND BLOOD					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	12,095,453		1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	4,527,763		2.00
3.00	DRUGS CHARGED TO PATIENTS	73.00	0	11,368,750		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
18.00		0.00	0	0		18.00
19.00		0.00	0	0		19.00
20.00		0.00	0	0		20.00
21.00		0.00	0	0		21.00
22.00		0.00	0	0		22.00
23.00		0.00	0	0		23.00
24.00		0.00	0	0		24.00
25.00		0.00	0	0		25.00
26.00		0.00	0	0		26.00
27.00		0.00	0	0		27.00
28.00		0.00	0	0		28.00
29.00		0.00	0	0		29.00
30.00		0.00	0	0		30.00
31.00		0.00	0	0		31.00
32.00		0.00	0	0		32.00
33.00		0.00	0	0		33.00
34.00		0.00	0	0		34.00
35.00		0.00	0	0		35.00
			0	27,991,966		
B - DIETARY						
1.00	CAFETERIA	11.00	567,444	1,145,263		1.00
			567,444	1,145,263		
D - INPATIENT L&D						
1.00	ADULTS & PEDIATRICS	30.00	685,093	359,043		1.00
2.00	NURSERY	43.00	380,940	144,618		2.00
			1,066,033	503,661		
E - UTILITIES						
1.00	OPERATION OF PLANT	7.00	0	250,969		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
			0	250,969		
F - PUMP						
1.00	ADULTS & PEDIATRICS	30.00	0	206,419		1.00
2.00	INTENSIVE CARE UNIT	31.00	0	20,284		2.00
3.00	SUBPROVIDER - IRF	41.00	0	19,457		3.00
4.00	NURSERY	43.00	0	16,913		4.00
			0	263,073		
G - MEDICAL PLAZA						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	1,229,431		1.00
			0	1,229,431		
J - ENDOSCOPY						
1.00	OPERATING ROOM	50.00	0	0		1.00
			0	0		
500.00	Grand Total: Increases		1,633,477	31,384,363		500.00

RECLASSIFICATIONS

Provider CCN: 14-0046

Period:
From 01/01/2023
To 12/31/2023

Worksheet A-6

Date/Time Prepared:
5/21/2024 10:06 am

	Decreases				Wkst. A-7 Ref.		
	Cost Center	Line #	Salary	Other			
	6.00	7.00	8.00	9.00	10.00		
	A - DRUG SUPPLY IMPLANT IV AND BLOOD						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	2,121	0		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	13,080	0		2.00
3.00	OPERATION OF PLANT	7.00	0	390	0		3.00
4.00	LAUNDRY & LINEN SERVICE	8.00	0	7,091	0		4.00
5.00	HOUSEKEEPING	9.00	0	45,530	0		5.00
6.00	DIETARY	10.00	0	239	0		6.00
7.00	NURSING ADMINISTRATION	13.00	0	2,772	0		7.00
8.00	CENTRAL SERVICES & SUPPLY	14.00	0	2,179	0		8.00
9.00	PHARMACY	15.00	0	11,525,371	0		9.00
10.00	SOCIAL SERVICE	17.00	0	5	0		10.00
11.00	ADULTS & PEDIATRICS	30.00	0	1,014,152	0		11.00
12.00	INTENSIVE CARE UNIT	31.00	0	452,714	0		12.00
13.00	SUBPROVIDER - IRF	41.00	0	51,705	0		13.00
14.00	OPERATING ROOM	50.00	0	7,411,677	0		14.00
15.00	RECOVERY ROOM	51.00	0	226,618	0		15.00
16.00	DELIVERY ROOM & LABOR ROOM	52.00	0	505,712	0		16.00
17.00	ANESTHESIOLOGY	53.00	0	285,762	0		17.00
18.00	RADIOLOGY-DIAGNOSTIC	54.00	0	92,967	0		18.00
19.00	RADIOLOGY-THERAPEUTIC	55.00	0	187,290	0		19.00
20.00	RADIOISOTOPE	56.00	0	11,564	0		20.00
21.00	CT SCAN	57.00	0	71,418	0		21.00
22.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	20,055	0		22.00
23.00	CARDIAC CATHETERIZATION	59.00	0	2,598,903	0		23.00
24.00	LABORATORY	60.00	0	2,197,030	0		24.00
25.00	INTRAVENOUS THERAPY	64.00	0	13,664	0		25.00
26.00	RESPIRATORY THERAPY	65.00	0	223,715	0		26.00
27.00	PHYSICAL THERAPY	66.00	0	10,335	0		27.00
28.00	OCCUPATIONAL THERAPY	67.00	0	4,783	0		28.00
29.00	SPEECH PATHOLOGY	68.00	0	755	0		29.00
30.00	ELECTROCARDIOLOGY	69.00	0	170,796	0		30.00
31.00	CARDIAC REHABILITATION	69.01	0	2,819	0		31.00
32.00	ELECTROENCEPHALOGRAPHY	70.00	0	566	0		32.00
33.00	RENAL DIALYSIS	74.00	0	11,932	0		33.00
34.00	CLINIC	90.00	0	329,878	0		34.00
35.00	EMERGENCY	91.00	0	496,378	0		35.00
			0	27,991,966			
	B - DIETARY						
1.00	DIETARY	10.00	567,444	1,145,263	0		1.00
			567,444	1,145,263			
	D - INPATIENT L&D						
1.00	INTENSIVE CARE UNIT	31.00	244,540	192,132	0		1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	821,493	311,529	0		2.00
			1,066,033	503,661			
	E - UTILITIES						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	5,014	0		1.00
2.00	HOUSEKEEPING	9.00	0	587	0		2.00
3.00	CLINIC	90.00	0	832	0		3.00
4.00	OTHER_NRB_COST_CENTER	194.00	0	244,536	0		4.00
			0	250,969			
	F - PUMP						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	263,073	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
			0	263,073			
	G - MEDICAL PLAZA						
1.00	OTHER_NRB_COST_CENTER	194.00	0	1,229,431	0		1.00
			0	1,229,431			
	J - ENDOSCOPY						
1.00	ENDOSCOPY	76.00	0	0	0		1.00
			0	0	0		
500.00	Grand Total: Decreases		1,633,477	31,384,363			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0046

Period:
From 01/01/2023
To 12/31/2023Worksheet A-7
Part I
Date/Time Prepared:
5/21/2024 10:06 am

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
			1.00	2.00	3.00		
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	590,251	0	0	0	0	1.00
2.00	Land Improvements	6,818,606	125,160	0	125,160	0	2.00
3.00	Buildings and Fixtures	160,879,485	432,059	-233,627	198,432	0	3.00
4.00	Building Improvements	32,542,095	67,907	0	67,907	0	4.00
5.00	Fixed Equipment	15,697,274	711,882	0	711,882	0	5.00
6.00	Movable Equipment	63,536,470	3,660,860	233,627	3,894,487	2,027,042	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	280,064,181	4,997,868	0	4,997,868	2,027,042	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	280,064,181	4,997,868	0	4,997,868	2,027,042	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	590,251	0				1.00
2.00	Land Improvements	6,943,766	0				2.00
3.00	Buildings and Fixtures	161,077,917	0				3.00
4.00	Building Improvements	32,610,002	0				4.00
5.00	Fixed Equipment	16,409,156	0				5.00
6.00	Movable Equipment	65,403,915	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	283,035,007	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	283,035,007	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0046

Period:
From 01/01/2023
To 12/31/2023Worksheet A-7
Part II
Date/Time Prepared:
5/21/2024 10:06 am

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	5,798,633	0	1,025,768	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	4,536,235	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	10,334,868	0	1,025,768	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of col.s. 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	6,824,401				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	4,536,235				2.00
3.00	Total (sum of lines 1-2)	0	11,360,636				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0046

Period:
From 01/01/2023
To 12/31/2023Worksheet A-7
Part III
Date/Time Prepared:
5/21/2024 10:06 am

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	201,221,937	0	201,221,937	0.710944	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	81,813,071	0	81,813,071	0.289056	0	2.00
3.00	Total (sum of lines 1-2)	283,035,008	0	283,035,008	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital -Related Costs	Total (sum of col.s. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	5,999,881	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	4,600,280	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	10,600,161	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital -Related Costs (see instructions)	Total (2) (sum of col.s. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	323,557	0	0	0	6,323,438	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	4,600,280	2.00
3.00	Total (sum of lines 1-2)	323,557	0	0	0	10,923,718	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0046

Period:
From 01/01/2023
To 12/31/2023

Worksheet A-8

Date/Time Prepared:
5/21/2024 10:06 am

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A		0ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-15,238,693			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	-7,865,886			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-642,662	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	B		0PHARMACY	15.00	0	16.00
17.00	Sale of drugs to other than patients	B	-67,069	PHARMACY	15.00	0	17.00
18.00	Sale of medical records and abstracts	B	-1,688	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		0RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		0PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)			0*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT	A	-3,142	CAP REL COSTS-BLDG & FIXT	1.00	9	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP	A	-774,495	CAP REL COSTS-MVBLE EQUIP	2.00	9	27.00
28.00	Non-physician Anesthetist			0*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		0OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)			0ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		0SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	MISCELLANEOUS REVENUE	B	-1,843,619	ADMINISTRATIVE & GENERAL	5.00	0	33.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0046

Period:
From 01/01/2023
To 12/31/2023

Worksheet A-8

Date/Time Prepared:
5/21/2024 10:06 am

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
33.01	MI SCCELLANEOUS REVENUE	B	-9,193	OPERATION OF PLANT	7.00	0	33.01
33.02	MI SCCELLANEOUS REVENUE	B	-2,296	HOUSEKEEPING	9.00	0	33.02
33.03	MI SCCELLANEOUS REVENUE	B	-2	NURSING ADMINISTRATION	13.00	0	33.03
33.04	MI SCCELLANEOUS REVENUE	B	-185,001	ADULTS & PEDIATRICS	30.00	0	33.04
33.06	MI SCCELLANEOUS REVENUE	B	-1,121	INTENSIVE CARE UNIT	31.00	0	33.06
33.07	MI SCCELLANEOUS REVENUE	B	-57,823	OPERATING ROOM	50.00	0	33.07
33.10	MI SCCELLANEOUS REVENUE	B	-1,300	DELIVERY ROOM & LABOR ROOM	52.00	0	33.10
33.12	MI SCCELLANEOUS REVENUE	B	-1,912	RADIOLOGY-DIAGNOSTIC	54.00	0	33.12
33.13	MI SCCELLANEOUS REVENUE	B	-32,732	RADIOLOGY-THERAPEUTIC	55.00	0	33.13
33.14	MI SCCELLANEOUS REVENUE	B	-148	RADIOISOTOPE	56.00	0	33.14
33.15	MI SCCELLANEOUS REVENUE	B	-9,956	CT SCAN	57.00	0	33.15
33.16	MI SCCELLANEOUS REVENUE	B	-23	LABORATORY	60.00	0	33.16
33.18	MI SCCELLANEOUS REVENUE	B	-4,882	RESPIRATORY THERAPY	65.00	0	33.18
33.19	MI SCCELLANEOUS REVENUE	B	-150	PHYSICAL THERAPY	66.00	0	33.19
33.21	MI SCCELLANEOUS REVENUE	B	-91	ELECTROCARDIOLOGY	69.00	0	33.21
33.22	MI SCCELLANEOUS REVENUE	B	-5,974	CLINIC	90.00	0	33.22
33.23	MARKETING	A	-1,334	ADMINISTRATIVE & GENERAL	5.00	0	33.23
33.24	MARKETING	A	-41	NURSING ADMINISTRATION	13.00	0	33.24
33.25	MARKETING	A	-63	ADULTS & PEDIATRICS	30.00	0	33.25
33.27	MARKETING	A	-2,086	SUBPROVIDER - IRF	41.00	0	33.27
33.28	MARKETING	A	-500	DELIVERY ROOM & LABOR ROOM	52.00	0	33.28
33.29	MARKETING	A	-663	RADIOLOGY-DIAGNOSTIC	54.00	0	33.29
33.30	MARKETING	A	-1,034	RADIOLOGY-THERAPEUTIC	55.00	0	33.30
34.00	MARKETING	A	-1,719	CLINIC	90.00	0	34.00
34.01	RECRUITMENT	A	-22,281	ADMINISTRATIVE & GENERAL	5.00	0	34.01
34.02	RECRUITMENT	A	-138	HOUSEKEEPING	9.00	0	34.02
34.03	RECRUITMENT	A	-317,806	NURSING ADMINISTRATION	13.00	0	34.03
34.04	RECRUITMENT	A	-46,140	ADULTS & PEDIATRICS	30.00	0	34.04
35.01	GIFT	B	-44,780	ADMINISTRATIVE & GENERAL	5.00	0	35.01
35.02	GIFT	B	-1,843	NURSING ADMINISTRATION	13.00	0	35.02
36.00	GIFT	B	-10	PHARMACY	15.00	0	36.00
37.00	GIFT	B	-520	ADULTS & PEDIATRICS	30.00	0	37.00
37.01	GIFT	B	-110	INTENSIVE CARE UNIT	31.00	0	37.01
37.02	GIFT	B	-10	SUBPROVIDER - IRF	41.00	0	37.02
37.03	GIFT	B	-1,881	DELIVERY ROOM & LABOR ROOM	52.00	0	37.03
37.04	GIFT	B	-97	RADIOLOGY-DIAGNOSTIC	54.00	0	37.04
37.05	GIFT	B	-294	RADIOLOGY-THERAPEUTIC	55.00	0	37.05
37.06	GIFT	B	-750	RESPIRATORY THERAPY	65.00	0	37.06
37.07	GIFT	B	-386	CLINIC	90.00	0	37.07
37.08	GIFT	B	-2,016	EMERGENCY	91.00	0	37.08
37.10	GIFT	B	-1,040	ADMINISTRATIVE & GENERAL	5.00	0	37.10
37.11	INTEREST	A	-707,204	CAP REL COSTS-BLDG & FIXT	1.00	11	37.11
37.12	PHYSICIAN PART A BENEFITS	A	-1,862,580	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	37.12
37.13	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	37.13
37.15	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	37.15
37.16	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	37.16
37.17	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	37.17
37.18	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	37.18
37.19	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	37.19
37.20	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	37.20
37.21	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	37.21
38.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	38.00
41.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	41.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-29,767,184				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.

			Provider CCN: 14-0046	Period: From 01/01/2023 To 12/31/2023	Worksheet A-8 Date/Time Prepared: 5/21/2024 10:06 am	
Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
			Cost Center	Line #	Wkst. A-7 Ref.	
	1.00	2.00	3.00	4.00	5.00	

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: 14-0046

Period:
From 01/01/2023
To 12/31/2023

Worksheet A-8-1

Date/Time Prepared:
5/21/2024 10:06 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00		1.00	CAP REL COSTS-BLDG & FIXT	HOME OFFICE	216,754	12,364 1.00
2.00		2.00	CAP REL COSTS-MVBLE EQUIP	HOME OFFICE	990,018	151,478 2.00
3.00		1.00	CAP REL COSTS-BLDG & FIXT	HOME OFFICE - INTEREST	0	-4,993 3.00
4.00		4.00	EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE	9,240,771	679,853 4.00
4.01		5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE	21,476,051	36,363,401 4.01
4.02		7.00	OPERATION OF PLANT	HOME OFFICE	0	69,112 4.02
4.03		14.00	CENTRAL SERVICES & SUPPLY	HOME OFFICE	0	38,348 4.03
4.04		71.00	MEDICAL SUPPLIES CHARGED TO	HOME OFFICE	-1,543,259	0 4.04
4.05		194.00	OTHER NRB COST CENTER	HOME OFFICE	0	936,658 4.05
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.				30,380,335	38,246,221 5.00

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

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

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

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

6.00	G	SSM HEALTH	100.00	FRAN SISTERS	100.00	6.00
7.00	G	SSM HEALTH	100.00	FRAN SISTERS	100.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:	CHURCH				100.00

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

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

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

Provider CCN: 14-0046

Period:
From 01/01/2023
To 12/31/2023

Worksheet A-8-1

Date/Time Prepared:
5/21/2024 10:06 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	204,390	9		1.00
2.00	838,540	9		2.00
3.00	4,993	11		3.00
4.00	8,560,918	0		4.00
4.01	-14,887,350	0		4.01
4.02	-69,112	0		4.02
4.03	-38,348	0		4.03
4.04	-1,543,259	0		4.04
4.05	-936,658	0		4.05
5.00	-7,865,886			5.00

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

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

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

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

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

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-0046

Period:
From 01/01/2023
To 12/31/2023

Worksheet A-8-2

Date/Time Prepared:
5/21/2024 10:06 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	98,260	98,260	0	211,500	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	5,709,136	5,652,826	56,310	197,500	311	2.00
3.00	31.00	INTENSIVE CARE UNIT	1,179,046	1,131,008	48,038	211,500	214	3.00
4.00	41.00	SUBPROVIDER - IRF	251,050	106,262	144,788	181,301	965	4.00
5.00	50.00	OPERATING ROOM	255,990	255,990	0	246,400	0	5.00
6.00	53.00	ANESTHESIOLOGY	5,645,519	5,645,519	0	239,400	0	6.00
7.00	55.00	RADIOLOGY-THERAPEUTIC	244,000	244,000	0	271,900	0	7.00
8.00	57.00	CT SCAN	292,081	292,081	0	271,900	0	8.00
9.00	60.00	LABORATORY	339,262	339,262	0	260,300	0	9.00
10.00	65.00	RESPIRATORY THERAPY	2,813	2,813	0	211,500	0	10.00
11.00	69.00	ELECTROCARDIOLOGY	502,298	238,432	263,866	211,500	1,376	11.00
12.00	69.01	CARDIAC REHABILITATION	-6,351	-26,112	19,761	211,500	128	12.00
13.00	70.00	ELECTROENCEPHALOGRAPHY	11,050	1,700	9,350	211,500	52	13.00
14.00	74.00	RENAL DIALYSIS	67,830	-14,500	82,330	197,500	478	14.00
15.00	90.00	CLINIC	72,182	72,182	0	197,500	0	15.00
16.00	91.00	EMERGENCY	966,993	854,326	112,667	197,500	563	16.00
200.00			15,631,159	14,894,049	737,110		4,087	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	29,530	1,477	0	0	0	2.00
3.00	31.00	INTENSIVE CARE UNIT	21,760	1,088	0	0	0	3.00
4.00	41.00	SUBPROVIDER - IRF	84,113	4,206	0	0	0	4.00
5.00	50.00	OPERATING ROOM	0	0	0	0	0	5.00
6.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	6.00
7.00	55.00	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	7.00
8.00	57.00	CT SCAN	0	0	0	0	0	8.00
9.00	60.00	LABORATORY	0	0	0	0	0	9.00
10.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	10.00
11.00	69.00	ELECTROCARDIOLOGY	139,915	6,996	0	0	0	11.00
12.00	69.01	CARDIAC REHABILITATION	13,015	651	0	0	0	12.00
13.00	70.00	ELECTROENCEPHALOGRAPHY	5,288	264	0	0	0	13.00
14.00	74.00	RENAL DIALYSIS	45,387	2,269	0	0	0	14.00
15.00	90.00	CLINIC	0	0	0	0	0	15.00
16.00	91.00	EMERGENCY	53,458	2,673	0	0	0	16.00
200.00			392,466	19,624	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	98,260		1.00
2.00	30.00	ADULTS & PEDIATRICS	0	29,530	26,780	5,679,606		2.00
3.00	31.00	INTENSIVE CARE UNIT	0	21,760	26,278	1,157,286		3.00
4.00	41.00	SUBPROVIDER - IRF	0	84,113	60,675	166,937		4.00
5.00	50.00	OPERATING ROOM	0	0	0	255,990		5.00
6.00	53.00	ANESTHESIOLOGY	0	0	0	5,645,519		6.00
7.00	55.00	RADIOLOGY-THERAPEUTIC	0	0	0	244,000		7.00
8.00	57.00	CT SCAN	0	0	0	292,081		8.00
9.00	60.00	LABORATORY	0	0	0	339,262		9.00
10.00	65.00	RESPIRATORY THERAPY	0	0	0	2,813		10.00
11.00	69.00	ELECTROCARDIOLOGY	0	139,915	123,951	362,383		11.00
12.00	69.01	CARDIAC REHABILITATION	0	13,015	6,746	-19,366		12.00
13.00	70.00	ELECTROENCEPHALOGRAPHY	0	5,288	4,062	5,762		13.00
14.00	74.00	RENAL DIALYSIS	0	45,387	36,943	22,443		14.00
15.00	90.00	CLINIC	0	0	0	72,182		15.00
16.00	91.00	EMERGENCY	0	53,458	59,209	913,535		16.00
200.00			0	392,466	344,644	15,238,693		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0046

Period:
From 01/01/2023
To 12/31/2023Worksheet B
Part I
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Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	4.00	4A
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	6,323,438	6,323,438			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	4,600,280		4,600,280		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	29,367,881	159,749	0	29,527,630	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	32,879,940	852,050	77,905	1,860,281	5.00
7.00	00700	OPERATION OF PLANT	6,271,848	1,011,850	2,412,842	499,293	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	673,267	69,760	0	44,612	8.00
9.00	00900	HOUSEKEEPING	2,296,581	162,669	4,453	776,746	9.00
10.00	01000	DIETARY	804,885	62,804	3,557	125,316	10.00
11.00	01100	CAFETERIA	1,070,045	164,048	0	266,580	11.00
13.00	01300	NURSING ADMINISTRATION	1,745,258	31,123	171,931	436,986	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	351,399	0	812	206,311	14.00
15.00	01500	PHARMACY	2,587,418	55,421	1,460	1,031,037	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	26,268	66,512	0	0	16.00
17.00	01700	SOCIAL SERVICE	2,145	56,996	0	0	17.00
23.00	02300	PARAMED PRGM-LABORATORY ED	71	10,500	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	16,315,931	919,612	0	8,378,707	30.00
31.00	03100	INTENSIVE CARE UNIT	2,490,971	287,325	12,960	1,172,995	31.00
41.00	04100	SUBPROVIDER - IIRF	2,329,860	148,117	44,531	795,593	41.00
43.00	04300	NURSERY	1,086,176	17,571	84	434,389	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	4,572,536	532,946	374,094	1,160,905	50.00
51.00	05100	RECOVERY ROOM	947,916	0	0	438,076	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,192,475	158,486	38,199	1,401,778	52.00
53.00	05300	ANESTHESIOLOGY	216,824	4,200	24,373	19,673	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,814,890	367,356	53,288	811,583	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	1,542,300	0	84,246	618,504	55.00
56.00	05600	RADIOISOTOPE	641,534	0	571	86,952	56.00
57.00	05700	CT SCAN	809,713	63,279	69,463	274,159	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	345,367	35,618	139,152	113,184	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,475,275	108,036	88,248	438,577	59.00
60.00	06000	LABORATORY	3,987,440	145,771	63,122	1,173,780	60.00
64.00	06400	INTRAVENOUS THERAPY	223,606	22,214	0	102,987	64.00
65.00	06500	RESPIRATORY THERAPY	2,171,438	24,150	33,819	837,631	65.00
66.00	06600	PHYSICAL THERAPY	1,219,200	61,360	1,063	490,064	66.00
66.01	03951	CLINICAL NUTRITION	156,554	0	0	73,403	66.01
67.00	06700	OCCUPATIONAL THERAPY	554,607	56,487	308	240,259	67.00
68.00	06800	SPEECH PATHOLOGY	332,964	11,173	562	153,901	68.00
69.00	06900	ELECTROCARDIOLOGY	2,496,731	287,440	36,859	943,670	69.00
69.01	06901	CARDIAC REHABILITATION	151,479	0	7,332	63,099	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	35,921	21,312	221	13,983	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	10,552,194	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,527,763	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	12,737,183	0	788	554,511	73.00
74.00	07400	RENAL DIALYSIS	976,814	0	0	0	74.00
76.00	03950	ENDOSCOPY	0	0	0	0	76.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	5,285,556	52,090	39,565	1,694,147	90.00
91.00	09100	EMERGENCY	3,671,556	255,677	5,368	1,264,644	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS							
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	175,863,498	6,283,702	3,791,176	28,998,316	174,485,344
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	40,224	23,346	535	18,895	190.00
191.00	19100	RESEARCH	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	-357,468	5,923	180,867	0	-170,678
194.00	07950	OTHER NRB COST CENTER	238,008	10,467	625,416	308,710	1,182,601
194.01	07951	OTHER NRB COST CENTER	0	0	0	0	0
194.02	07952	NONREIMBURSABLE COST CENTER	0	0	0	0	0
194.03	07953	RETAIL PHARMACY	8,133,139	0	2,286	201,709	8,337,134
200.00		Cross Foot Adjustments					0
201.00		Negative Cost Centers		0	0	0	0
202.00		TOTAL (sum lines 118 through 201)	183,917,401	6,323,438	4,600,280	29,527,630	183,917,401

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0046

Period:
From 01/01/2023
To 12/31/2023Worksheet B
Part I
Date/Time Prepared:
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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	35,670,176					5.00
7.00	00700	OPERATION OF PLANT	2,450,426	12,646,259				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	189,298	205,174	1,182,111			8.00
9.00	00900	HOUSEKEEPING	778,797	478,433	0	4,497,679		9.00
10.00	01000	DIETARY	239,510	184,714	0	69,448	1,490,234	10.00
11.00	01100	CAFETERIA	360,666	482,486	0	181,404	0	11.00
13.00	01300	NURSING ADMINISTRATION	573,273	91,537	0	34,416	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	134,233	0	0	0	0	14.00
15.00	01500	PHARMACY	883,316	163,000	0	61,284	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	22,298	195,619	0	73,548	0	16.00
17.00	01700	SOCIAL SERVICE	14,214	167,632	0	63,026	0	17.00
23.00	02300	PARAMED ED PRGM-LABORATORY ED	2,541	30,882	0	11,611	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	6,156,033	2,704,702	925,079	1,016,907	1,166,206	30.00
31.00	03100	INTENSIVE CARE UNIT	952,752	845,062	93,616	317,724	118,018	31.00
41.00	04100	SUBPROVIDER - IIRF	797,459	435,632	86,607	163,787	109,181	41.00
43.00	04300	NURSERY	369,690	51,679	76,809	19,430	96,829	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,595,947	1,567,464	0	589,330	0	50.00
51.00	05100	RECOVERY ROOM	333,104	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,151,435	466,128	0	175,253	0	52.00
53.00	05300	ANESTHESIOLOGY	63,706	12,353	0	4,644	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	732,332	1,080,443	0	406,221	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	539,566	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	175,219	0	0	5,219	0	56.00
57.00	05700	CT SCAN	292,396	186,113	0	69,974	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	152,210	104,758	0	39,387	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	507,142	317,749	0	119,466	0	59.00
60.00	06000	LABORATORY	1,290,631	428,732	0	161,193	0	60.00
64.00	06400	INTRAVENOUS THERAPY	83,831	65,335	0	24,564	0	64.00
65.00	06500	RESPIRATORY THERAPY	737,120	71,029	0	26,705	0	65.00
66.00	06600	PHYSICAL THERAPY	425,800	180,468	0	67,852	0	66.00
66.01	03951	CLINICAL NUTRITION	55,267	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	204,685	166,137	0	62,463	0	67.00
68.00	06800	SPEECH PATHOLOGY	119,832	32,861	0	12,355	0	68.00
69.00	06900	ELECTROCARDIOLOGY	904,793	845,400	0	317,851	0	69.00
69.01	06901	CARDIAC REHABILITATION	53,333	0	0	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	17,169	62,681	0	23,567	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,536,072	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,088,184	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,194,662	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	234,764	0	0	0	0	74.00
76.00	03950	ENDOSCOPY	0	0	0	0	0	76.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	1,699,502	153,205	0	57,601	0	90.00
91.00	09100	EMERGENCY	1,249,085	751,981	0	282,728	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	33,362,293	12,529,389	1,182,111	4,453,739	1,490,234	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	19,948	68,665	0	25,816	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	17,419	0	6,549	0	192.00
194.00	07950	OTHER NRB COST CENTER	284,222	30,786	0	11,575	0	194.00
194.01	07951	OTHER NRB COST CENTER	0	0	0	0	0	194.01
194.02	07952	NONREIMBURSABLE COST CENTER	0	0	0	0	0	194.02
194.03	07953	RETAIL PHARMACY	2,003,713	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	35,670,176	12,646,259	1,182,111	4,497,679	1,490,234	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0046

Period:
From 01/01/2023
To 12/31/2023Worksheet B
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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	2,525,229					11.00
13.00	01300	NURSING ADMINISTRATION	42,515	3,127,039				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	20,072	0	712,827			14.00
15.00	01500	PHARMACY	100,312	0	0	4,883,248		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	384,245	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
23.00	02300	PARAMED ED PRGM-LABARATORY ED	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	815,210	1,110,152	59,252	271,668	31,252	30.00
31.00	03100	INTENSIVE CARE UNIT	114,123	262,183	26,337	37,597	3,897	31.00
41.00	04100	SUBPROVIDER - IRF	77,405	124,043	3,083	6,266	3,001	41.00
43.00	04300	NURSERY	42,263	92,046	0	0	1,988	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	112,947	186,554	253,451	936,836	52,655	50.00
51.00	05100	RECOVERY ROOM	42,621	102,285	13,507	4,286	7,577	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	136,382	309,547	30,153	92,604	11,671	52.00
53.00	05300	ANESTHESIOLOGY	1,914	0	17,038	574,299	17,256	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	78,961	12,239	5,536	48,904	12,770	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	60,176	40,582	9,946	85,685	2,355	55.00
56.00	05600	RADIOISOTOPE	8,460	0	689	112,749	6,076	56.00
57.00	05700	CT SCAN	26,674	55	4,258	159,796	42,616	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	11,012	192	1,196	11,063	7,353	58.00
59.00	05900	CARDIAC CATHETERIZATION	42,670	51,431	78,426	14,022	24,807	59.00
60.00	06000	LABORATORY	114,200	0	130,996	3,858	45,462	60.00
64.00	06400	INTRAVENOUS THERAPY	10,020	21,923	815	4,266	559	64.00
65.00	06500	RESPIRATORY THERAPY	81,495	857	13,191	33,678	7,653	65.00
66.00	06600	PHYSICAL THERAPY	47,680	0	616	1,286	4,415	66.00
66.01	03951	CLINICAL NUTRITION	7,142	0	0	0	13	66.01
67.00	06700	OCCUPATIONAL THERAPY	23,375	0	277	1,980	1,984	67.00
68.00	06800	SPEECH PATHOLOGY	14,973	0	45	0	1,122	68.00
69.00	06900	ELECTROCARDIOLOGY	91,812	131,550	10,184	847,886	14,086	69.00
69.01	06901	CARDIAC REHABILITATION	6,139	20,049	168	980	415	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	1,360	0	34	1,612	120	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	7,787	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	5,246	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	53,950	134,919	5,350	7,103	35,852	73.00
74.00	07400	RENAL DIALYSIS	0	0	711	61	1,181	74.00
76.00	03950	ENDOSCOPY	0	0	0	0	0	76.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	164,828	286,964	18,032	1,559,999	7,491	90.00
91.00	09100	EMERGENCY	123,040	239,155	29,536	64,764	25,585	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,473,731	3,126,726	712,827	4,883,248	384,245	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,838	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	313	0	0	0	192.00
194.00	07950	OTHER NRB COST CENTER	30,035	0	0	0	0	194.00
194.01	07951	OTHER NRB COST CENTER	0	0	0	0	0	194.01
194.02	07952	NONREIMBURSABLE COST CENTER	0	0	0	0	0	194.02
194.03	07953	RETAIL PHARMACY	19,625	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	2,525,229	3,127,039	712,827	4,883,248	384,245	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0046

Period:
From 01/01/2023
To 12/31/2023Worksheet B
Part I
Date/Time Prepared:
5/21/2024 10:06 am

Cost Center Description			SOCIAL SERVICE	PARAMED ED PRGM-LABORATORY ED	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			17.00	23.00	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	304,013					17.00
23.00	02300	PARAMED ED PRGM-LABORATORY ED	0	55,605				23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	237,911	0	40,108,622	0	40,108,622	30.00
31.00	03100	INTENSIVE CARE UNIT	24,076	0	6,759,636	0	6,759,636	31.00
41.00	04100	SUBPROVIDER - IRF	22,273	0	5,146,838	0	5,146,838	41.00
43.00	04300	NURSERY	19,753	0	2,308,707	0	2,308,707	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	11,935,665	0	11,935,665	50.00
51.00	05100	RECOVERY ROOM	0	0	1,889,372	0	1,889,372	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	7,164,111	0	7,164,111	52.00
53.00	05300	ANESTHESIOLOGY	0	0	956,280	0	956,280	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	5,424,523	0	5,424,523	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	2,983,360	0	2,983,360	55.00
56.00	05600	RADIOISOTOPE	0	0	1,032,250	0	1,032,250	56.00
57.00	05700	CT SCAN	0	0	1,998,496	0	1,998,496	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	960,492	0	960,492	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	3,265,849	0	3,265,849	59.00
60.00	06000	LABORATORY	0	55,605	7,600,790	0	7,600,790	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	560,120	0	560,120	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	4,038,766	0	4,038,766	65.00
66.00	06600	PHYSICAL THERAPY	0	0	2,499,804	0	2,499,804	66.00
66.01	03951	CLINICAL NUTRITION	0	0	292,379	0	292,379	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	1,312,562	0	1,312,562	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	679,788	0	679,788	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	6,928,262	0	6,928,262	69.00
69.01	06901	CARDIAC REHABILITATION	0	0	302,994	0	302,994	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	177,980	0	177,980	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	13,096,053	0	13,096,053	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	5,621,193	0	5,621,193	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	16,724,318	0	16,724,318	73.00
74.00	07400	RENAL DIALYSIS	0	0	1,213,531	0	1,213,531	74.00
76.00	03950	ENDOSCOPY	0	0	0	0	0	76.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	11,018,980	0	11,018,980	90.00
91.00	09100	EMERGENCY	0	0	7,963,119	0	7,963,119	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS								
118.00	SUBTOTALS (SUM OF LINES 1 through 117)		304,013	55,605	171,964,840	0	171,964,840	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	199,267	0	199,267	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	-146,397	0	-146,397	192.00
194.00	07950	OTHER NRB COST CENTER	0	0	1,539,219	0	1,539,219	194.00
194.01	07951	OTHER NRB COST CENTER	0	0	0	0	0	194.01
194.02	07952	NONREIMBURSABLE COST CENTER	0	0	0	0	0	194.02
194.03	07953	RETAIL PHARMACY	0	0	10,360,472	0	10,360,472	194.03
200.00		Cross Foot Adjustments	0	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)	304,013	55,605	183,917,401	0	183,917,401	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0046

Period:
From 01/01/2023
To 12/31/2023Worksheet B
Part II
Date/Time Prepared:
5/21/2024 10:06 am

Cost Center Description			CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	2A	4.00
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	159,749	0	159,749	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	852,050	77,905	929,955	5.00
7.00	00700	OPERATION OF PLANT	0	1,011,850	2,412,842	3,424,692	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	69,760	0	69,760	8.00
9.00	00900	HOUSEKEEPING	0	162,669	4,453	167,122	9.00
10.00	01000	DIETARY	0	62,804	3,557	66,361	10.00
11.00	01100	CAFETERIA	0	164,048	0	164,048	11.00
13.00	01300	NURSING ADMINISTRATION	59,019	31,123	171,931	262,073	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	38	0	812	850	14.00
15.00	01500	PHARMACY	263,073	55,421	1,460	319,954	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	66,512	0	66,512	16.00
17.00	01700	SOCIAL SERVICE	0	56,996	0	56,996	17.00
23.00	02300	PARAMED ED PRGM-LABARATORY ED	0	10,500	0	10,500	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	109,347	919,612	0	1,028,959	30.00
31.00	03100	INTENSIVE CARE UNIT	4,660	287,325	12,960	304,945	31.00
41.00	04100	SUBPROVIDER - IRF	0	148,117	44,531	192,648	41.00
43.00	04300	NURSERY	0	17,571	84	17,655	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	107,340	532,946	374,094	1,014,380	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	158,486	38,199	196,685	52.00
53.00	05300	ANESTHESIOLOGY	0	4,200	24,373	28,573	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	367,356	53,288	420,644	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	33,660	0	84,246	117,906	55.00
56.00	05600	RADIOISOTOPE	0	0	571	571	56.00
57.00	05700	CT SCAN	0	63,279	69,463	132,742	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	35,618	139,152	174,770	58.00
59.00	05900	CARDIAC CATHETERIZATION	167	108,036	88,248	196,451	59.00
60.00	06000	LABORATORY	0	145,771	63,122	208,893	60.00
64.00	06400	INTRAVENOUS THERAPY	0	22,214	0	22,214	64.00
65.00	06500	RESPIRATORY THERAPY	122,507	24,150	33,819	180,476	65.00
66.00	06600	PHYSICAL THERAPY	684	61,360	1,063	63,107	66.00
66.01	03951	CLINICAL NUTRITION	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	56,487	308	56,795	67.00
68.00	06800	SPEECH PATHOLOGY	0	11,173	562	11,735	68.00
69.00	06900	ELECTROCARDIOLOGY	180,525	287,440	36,859	504,824	69.00
69.01	06901	CARDIAC REHABILITATION	0	0	7,332	7,332	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	21,312	221	21,533	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	788	788	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
76.00	03950	ENDOSCOPY	0	0	0	0	76.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	1,041,268	52,090	39,565	1,132,923	90.00
91.00	09100	EMERGENCY	0	255,677	5,368	261,045	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0	92.00
OTHER REIMBURSABLE COST CENTERS							
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,922,288	6,283,702	3,791,176	11,997,166	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	23,346	535	23,881	190.00
191.00	19100	RESEARCH	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	48,864	5,923	180,867	235,654	192.00
194.00	07950	OTHER NRB COST CENTER	1,180,810	10,467	625,416	1,816,693	194.00
194.01	07951	OTHER NRB COST CENTER	0	0	0	0	194.01
194.02	07952	NONREIMBURSABLE COST CENTER	0	0	0	0	194.02
194.03	07953	RETAIL PHARMACY	0	0	2,286	2,286	194.03
200.00		Cross Foot Adjustments				0	200.00
201.00		Negative Cost Centers		0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	3,151,962	6,323,438	4,600,280	14,075,680	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0046

Period:
From 01/01/2023
To 12/31/2023Worksheet B
Part II
Date/Time Prepared:
5/21/2024 10:06 am

Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	940,021				5.00
7.00	00700	OPERATION OF PLANT	64,580	3,491,974			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	4,989	56,654	131,644		8.00
9.00	00900	HOUSEKEEPING	20,525	132,108	0	323,958	9.00
10.00	01000	DIETARY	6,312	51,005	0	5,002	129,358 10.00
11.00	01100	CAFETERIA	9,505	133,227	0	13,066	0 11.00
13.00	01300	NURSING ADMINISTRATION	15,108	25,276	0	2,479	0 13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,538	0	0	0	0 14.00
15.00	01500	PHARMACY	23,280	45,009	0	4,414	0 15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	588	54,016	0	5,298	0 16.00
17.00	01700	SOCIAL SERVICE	375	46,288	0	4,540	0 17.00
23.00	02300	PARAMED ED PRGM-LABORATORY ED	67	8,527	0	836	0 23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	162,181	746,840	103,020	73,246	101,232 30.00
31.00	03100	INTENSIVE CARE UNIT	25,110	233,345	10,425	22,885	10,244 31.00
41.00	04100	SUBPROVIDER - IIRF	21,017	120,290	9,645	11,797	9,477 41.00
43.00	04300	NURSERY	9,743	14,270	8,554	1,400	8,405 43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	42,061	432,819	0	42,448	0 50.00
51.00	05100	RECOVERY ROOM	8,779	0	0	0	0 51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	30,346	128,711	0	12,623	0 52.00
53.00	05300	ANESTHESIOLOGY	1,679	3,411	0	335	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	19,300	298,339	0	29,259	0 54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	14,220	0	0	0	0 55.00
56.00	05600	RADIOISOTOPE	4,618	0	0	0	0 56.00
57.00	05700	CT SCAN	7,706	51,391	0	5,040	0 57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	4,011	28,927	0	2,837	0 58.00
59.00	05900	CARDIAC CATHETERIZATION	13,366	87,739	0	8,605	0 59.00
60.00	06000	LABORATORY	34,014	118,384	0	11,610	0 60.00
64.00	06400	INTRAVENOUS THERAPY	2,209	18,041	0	1,769	0 64.00
65.00	06500	RESPIRATORY THERAPY	19,427	19,613	0	1,924	0 65.00
66.00	06600	PHYSICAL THERAPY	11,222	49,832	0	4,887	0 66.00
66.01	03951	CLINICAL NUTRITION	1,457	0	0	0	0 66.01
67.00	06700	OCCUPATIONAL THERAPY	5,394	45,875	0	4,499	0 67.00
68.00	06800	SPEECH PATHOLOGY	3,158	9,074	0	890	0 68.00
69.00	06900	ELECTROCARDIOLOGY	23,846	233,438	0	22,846	0 69.00
69.01	06901	CARDIAC REHABILITATION	1,406	0	0	0	0 69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	452	17,308	0	1,697	0 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	66,838	0	0	0	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	28,679	0	0	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	84,195	0	0	0	0 73.00
74.00	07400	RENAL DIALYSIS	6,187	0	0	0	0 74.00
76.00	03950	ENDOSCOPY	0	0	0	0	0 76.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0 77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0 78.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	44,790	42,304	0	4,149	0 90.00
91.00	09100	EMERGENCY	32,919	207,642	0	20,364	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS							
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0 102.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	879,197	3,459,703	131,644	320,793	129,358 118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	526	18,960	0	1,859	0 190.00
191.00	19100	RESEARCH	0	0	0	0	0 191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	4,810	0	472	0 192.00
194.00	07950	OTHER NRB COST CENTER	7,491	8,501	0	834	0 194.00
194.01	07951	OTHER NRB COST CENTER	0	0	0	0	0 194.01
194.02	07952	NONREIMBURSABLE COST CENTER	0	0	0	0	0 194.02
194.03	07953	RETAIL PHARMACY	52,807	0	0	0	0 194.03
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers	0	0	0	0	0 201.00
202.00		TOTAL (sum lines 118 through 201)	940,021	3,491,974	131,644	323,958	129,358 202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0046

Period:
From 01/01/2023
To 12/31/2023Worksheet B
Part II
Date/Time Prepared:
5/21/2024 10:06 am

Cost Center Description			CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	321,288					11.00
13.00	01300	NURSING ADMINISTRATION	5,409	312,710				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,554	0	8,058			14.00
15.00	01500	PHARMACY	12,762	0	0	410,998		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	126,414	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
23.00	02300	PARAMED ED PRGM-LABARATORY ED	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	103,729	111,018	670	22,865	10,300	30.00
31.00	03100	INTENSIVE CARE UNIT	14,519	26,219	298	3,164	1,284	31.00
41.00	04100	SUBPROVIDER - IRF	9,848	12,405	35	527	989	41.00
43.00	04300	NURSERY	5,377	9,205	0	0	655	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	14,370	18,656	2,863	78,849	17,127	50.00
51.00	05100	RECOVERY ROOM	5,422	10,229	153	361	2,497	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	17,351	30,955	341	7,794	3,847	52.00
53.00	05300	ANESTHESIOLOGY	244	0	193	48,336	5,688	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,046	1,224	63	4,116	4,209	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	7,656	4,058	112	7,212	776	55.00
56.00	05600	RADIOISOTOPE	1,076	0	8	9,490	2,002	56.00
57.00	05700	CT SCAN	3,394	5	48	13,449	14,046	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,401	19	14	931	2,424	58.00
59.00	05900	CARDIAC CATHETERIZATION	5,429	5,143	887	1,180	8,176	59.00
60.00	06000	LABORATORY	14,529	0	1,481	325	14,984	60.00
64.00	06400	INTRAVENOUS THERAPY	1,275	2,192	9	359	184	64.00
65.00	06500	RESPIRATORY THERAPY	10,368	86	149	2,834	2,522	65.00
66.00	06600	PHYSICAL THERAPY	6,066	0	7	108	1,455	66.00
66.01	03951	CLINICAL NUTRITION	909	0	0	0	4	66.01
67.00	06700	OCCUPATIONAL THERAPY	2,974	0	3	167	654	67.00
68.00	06800	SPEECH PATHOLOGY	1,905	0	1	0	370	68.00
69.00	06900	ELECTROCARDIOLOGY	11,681	13,155	115	71,362	4,643	69.00
69.01	06901	CARDIAC REHABILITATION	781	2,005	2	82	137	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	173	0	0	136	40	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	2,566	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	1,729	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,864	13,492	60	598	11,816	73.00
74.00	07400	RENAL DIALYSIS	0	0	8	5	389	74.00
76.00	03950	ENDOSCOPY	0	0	0	0	0	76.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	20,970	28,697	204	131,297	2,469	90.00
91.00	09100	EMERGENCY	15,654	23,916	334	5,451	8,432	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	314,736	312,679	8,058	410,998	126,414	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	234	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	31	0	0	0	192.00
194.00	07950	OTHER NRB COST CENTER	3,821	0	0	0	0	194.00
194.01	07951	OTHER NRB COST CENTER	0	0	0	0	0	194.01
194.02	07952	NONREIMBURSABLE COST CENTER	0	0	0	0	0	194.02
194.03	07953	RETAIL PHARMACY	2,497	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	321,288	312,710	8,058	410,998	126,414	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0046

Period:
From 01/01/2023
To 12/31/2023Worksheet B
Part II
Date/Time Prepared:
5/21/2024 10:06 am

	Cost Center Description		SOCIAL SERVICE	PARAMED PRGM-LABARATORY ED	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			17.00	23.00	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	108,199					17.00
23.00	02300	PARAMED PRGM-LABARATORY ED	0	19,930				23.00
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	84,673		2,594,051	0	2,594,051	30.00
31.00	03100	INTENSIVE CARE UNIT	8,569		667,354	0	667,354	31.00
41.00	04100	SUBPROVIDER - IRF	7,927		400,910	0	400,910	41.00
43.00	04300	NURSERY	7,030		84,644	0	84,644	43.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0		1,669,855	0	1,669,855	50.00
51.00	05100	RECOVERY ROOM	0		29,811	0	29,811	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		436,238	0	436,238	52.00
53.00	05300	ANESTHESIOLOGY	0		88,565	0	88,565	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0		791,591	0	791,591	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0		155,287	0	155,287	55.00
56.00	05600	RADIOISOTOPE	0		18,235	0	18,235	56.00
57.00	05700	CT SCAN	0		229,304	0	229,304	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0		215,946	0	215,946	58.00
59.00	05900	CARDIAC CATHETERIZATION	0		329,349	0	329,349	59.00
60.00	06000	LABORATORY	0		410,571	0	410,571	60.00
64.00	06400	INTRAVENOUS THERAPY	0		48,809	0	48,809	64.00
65.00	06500	RESPIRATORY THERAPY	0		241,931	0	241,931	65.00
66.00	06600	PHYSICAL THERAPY	0		139,336	0	139,336	66.00
66.01	03951	CLINICAL NUTRITION	0		2,767	0	2,767	66.01
67.00	06700	OCCUPATIONAL THERAPY	0		117,661	0	117,661	67.00
68.00	06800	SPEECH PATHOLOGY	0		27,966	0	27,966	68.00
69.00	06900	ELECTROCARDIOLOGY	0		891,064	0	891,064	69.00
69.01	06901	CARDIAC REHABILITATION	0		12,086	0	12,086	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0		41,415	0	41,415	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0		69,404	0	69,404	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		30,408	0	30,408	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0		120,813	0	120,813	73.00
74.00	07400	RENAL DIALYSIS	0		6,589	0	6,589	74.00
76.00	03950	ENDOSCOPY	0		0	0	0	76.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0		0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0		0	0	0	78.00
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0		1,416,970	0	1,416,970	90.00
91.00	09100	EMERGENCY	0		582,600	0	582,600	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0	0	0	92.00
	OTHER REIMBURSABLE COST CENTERS							
102.00	10200	OPIOID TREATMENT PROGRAM	0		0	0	0	102.00
	SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	108,199	0	11,871,530	0	11,871,530	118.00
	NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		45,562	0	45,562	190.00
191.00	19100	RESEARCH	0		0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0		240,967	0	240,967	192.00
194.00	07950	OTHER NRB COST CENTER	0		1,839,010	0	1,839,010	194.00
194.01	07951	OTHER NRB COST CENTER	0		0	0	0	194.01
194.02	07952	NONREIMBURSABLE COST CENTER	0		0	0	0	194.02
194.03	07953	RETAIL PHARMACY	0		58,681	0	58,681	194.03
200.00		Cross Foot Adjustments		19,930	19,930	0	19,930	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	108,199	19,930	14,075,680	0	14,075,680	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0046

Period:
From 01/01/2023
To 12/31/2023

Worksheet B-1

Date/Time Prepared:
5/21/2024 10:06 am

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
			1.00	2.00	4.00	5A	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	385,425					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		10,334,868				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	9,737	0	62,852,781			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	51,934	175,020	3,959,813	-35,670,176	148,417,903	5.00
7.00	00700	OPERATION OF PLANT	61,674	5,420,624	1,062,801	0	10,195,833	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	4,252	0	94,961	0	787,639	8.00
9.00	00900	HOUSEKEEPING	9,915	10,004	1,653,390	0	3,240,449	9.00
10.00	01000	DIETARY	3,828	7,991	266,748	0	996,562	10.00
11.00	01100	CAFETERIA	9,999	0	567,444	0	1,500,673	11.00
13.00	01300	NURSING ADMINISTRATION	1,897	386,257	930,174	0	2,385,298	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,824	439,155	0	558,522	14.00
15.00	01500	PHARMACY	3,378	3,280	2,194,676	0	3,675,336	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,054	0	0	0	92,780	16.00
17.00	01700	SOCIAL SERVICE	3,474	0	0	0	59,141	17.00
23.00	02300	PARAMED PRGM-LABORATORY ED	640	0	0	0	10,571	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	56,052	0	17,834,957	0	25,614,250	30.00
31.00	03100	INTENSIVE CARE UNIT	17,513	29,115	2,496,849	0	3,964,251	31.00
41.00	04100	SUBPROVIDER - IRF	9,028	100,042	1,693,508	0	3,318,101	41.00
43.00	04300	NURSERY	1,071	188	924,645	0	1,538,220	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	32,484	840,431	2,471,114	0	6,640,481	50.00
51.00	05100	RECOVERY ROOM	0	0	932,493	0	1,385,992	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	9,660	85,816	2,983,840	0	4,790,938	52.00
53.00	05300	ANESTHESIOLOGY	256	54,756	41,877	0	265,070	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	22,391	119,715	1,727,545	0	3,047,117	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	189,264	1,316,555	0	2,245,050	55.00
56.00	05600	RADIOISOTOPE	0	1,282	185,088	0	729,057	56.00
57.00	05700	CT SCAN	3,857	156,053	583,578	0	1,216,614	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	2,171	312,616	240,924	0	633,321	58.00
59.00	05900	CARDIAC CATHETERIZATION	6,585	198,256	933,559	0	2,110,136	59.00
60.00	06000	LABORATORY	8,885	141,808	2,498,520	0	5,370,113	60.00
64.00	06400	INTRAVENOUS THERAPY	1,354	0	219,219	0	348,807	64.00
65.00	06500	RESPIRATORY THERAPY	1,472	75,977	1,782,990	0	3,067,038	65.00
66.00	06600	PHYSICAL THERAPY	3,740	2,388	1,043,156	0	1,771,687	66.00
66.01	03951	CLINICAL NUTRITION	0	0	156,247	0	229,957	66.01
67.00	06700	OCCUPATIONAL THERAPY	3,443	693	511,418	0	851,661	67.00
68.00	06800	SPEECH PATHOLOGY	681	1,263	327,596	0	498,600	68.00
69.00	06900	ELECTROCARDIOLOGY	17,520	82,806	2,008,707	0	3,764,700	69.00
69.01	06901	CARDIAC REHABILITATION	0	16,473	134,314	0	221,910	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	1,299	496	29,765	0	71,437	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	10,552,194	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	4,527,763	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,771	1,180,338	0	13,292,482	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	976,814	74.00
76.00	03950	ENDOSCOPY	0	0	0	0	0	76.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	3,175	88,885	3,606,180	0	7,071,358	90.00
91.00	09100	EMERGENCY	15,584	12,059	2,691,934	0	5,197,245	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	383,003	8,517,153	61,726,078	-35,670,176	138,815,168	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,423	1,203	40,220	0	83,000	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	361	406,332	0	170,678	0	192.00
194.00	07950	OTHER NRB COST CENTER	638	1,405,044	657,123	0	1,182,601	194.00
194.01	07951	OTHER NRB COST CENTER	0	0	0	0	0	194.01
194.02	07952	NONREIMBURSABLE COST CENTER	0	0	0	0	0	194.02
194.03	07953	RETAIL PHARMACY	0	5,136	429,360	0	8,337,134	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	6,323,438	4,600,280	29,527,630		35,670,176	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0046

Period:
From 01/01/2023
To 12/31/2023

Worksheet B-1

Date/Time Prepared:
5/21/2024 10:06 am

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
			1.00	2.00	4.00	5A	5.00	
203.00		Unit cost multiplier (Wkst. B, Part I)	16.406403	0.445122	0.469790		0.240336	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			159,749		940,021	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.002542		0.006334	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: 14-0046

Period:
From 01/01/2023
To 12/31/2023

Worksheet B-1

Date/Time Prepared:
5/21/2024 10:06 am

Cost Center Description			OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (TOTAL PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (TOTAL PATIENT DAYS)	CAFETERIA (GROSS SALARIES)	
			7.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	262,080					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	4,252	32,212				8.00
9.00	00900	HOUSEKEEPING	9,915	0	247,913			9.00
10.00	01000	DIETARY	3,828	0	3,828	32,212		10.00
11.00	01100	CAFETERIA	9,999	0	9,999	0	55,247,624	11.00
13.00	01300	NURSING ADMINISTRATION	1,897	0	1,897	0	930,174	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	439,155	14.00
15.00	01500	PHARMACY	3,378	0	3,378	0	2,194,676	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,054	0	4,054	0	0	16.00
17.00	01700	SOCIAL SERVICE	3,474	0	3,474	0	0	17.00
23.00	02300	PARAMED ED PRGM-LABARATORY ED	640	0	640	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	56,052	25,208	56,052	25,208	17,834,957	30.00
31.00	03100	INTENSIVE CARE UNIT	17,513	2,551	17,513	2,551	2,496,849	31.00
41.00	04100	SUBPROVIDER - I RF	9,028	2,360	9,028	2,360	1,693,508	41.00
43.00	04300	NURSERY	1,071	2,093	1,071	2,093	924,645	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	32,484	0	32,484	0	2,471,114	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	932,493	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	9,660	0	9,660	0	2,983,840	52.00
53.00	05300	ANESTHESIOLOGY	256	0	256	0	41,877	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	22,391	0	22,391	0	1,727,545	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	1,316,555	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	185,088	56.00
57.00	05700	CT SCAN	3,857	0	3,857	0	583,578	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	2,171	0	2,171	0	240,924	58.00
59.00	05900	CARDIAC CATHETERIZATION	6,585	0	6,585	0	933,559	59.00
60.00	06000	LABORATORY	8,885	0	8,885	0	2,498,520	60.00
64.00	06400	INTRAVENOUS THERAPY	1,354	0	1,354	0	219,219	64.00
65.00	06500	RESPIRATORY THERAPY	1,472	0	1,472	0	1,782,990	65.00
66.00	06600	PHYSICAL THERAPY	3,740	0	3,740	0	1,043,156	66.00
66.01	03951	CLINICAL NUTRITION	0	0	0	0	156,247	66.01
67.00	06700	OCCUPATIONAL THERAPY	3,443	0	3,443	0	511,418	67.00
68.00	06800	SPEECH PATHOLOGY	681	0	681	0	327,596	68.00
69.00	06900	ELECTROCARDIOLOGY	17,520	0	17,520	0	2,008,707	69.00
69.01	06901	CARDIAC REHABILITATION	0	0	0	0	134,314	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	1,299	0	1,299	0	29,765	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	1,180,338	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	ENDOSCOPY	0	0	0	0	0	76.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	3,175	0	3,175	0	3,606,180	90.00
91.00	09100	EMERGENCY	15,584	0	15,584	0	2,691,934	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	259,658	32,212	245,491	32,212	54,120,921	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,423	0	1,423	0	40,220	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	361	0	361	0	0	192.00
194.00	07950	OTHER NRB COST CENTER	638	0	638	0	657,123	194.00
194.01	07951	OTHER NRB COST CENTER	0	0	0	0	0	194.01
194.02	07952	NONREIMBURSABLE COST CENTER	0	0	0	0	0	194.02
194.03	07953	RETAIL PHARMACY	0	0	0	0	429,360	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	12,646,259	1,182,111	4,497,679	1,490,234	2,525,229	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	48.253430	36.697846	18.142167	46.263318	0.045707	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	3,491,974	131,644	323,958	129,358	321,288	204.00

COST ALLOCATION - STATISTICAL BASIS					Provider CCN: 14-0046		Period: From 01/01/2023 To 12/31/2023		Worksheet B-1 Date/Time Prepared: 5/21/2024 10:06 am	
Cost Center Description					OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (TOTAL PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (TOTAL PATIENT DAYS)	CAFETERIA (GROSS SALARIES)	
					7.00	8.00	9.00	10.00	11.00	
205.00		Unit cost multiplier (Wkst. B, Part II)	13.324077	4.086800	1.306741	4.015833	0.005815	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: 14-0046

Period:
From 01/01/2023
To 12/31/2023

Worksheet B-1

Date/Time Prepared:
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Cost Center Description			NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TOTAL PATIENT DAYS)	
			13.00	14.00	15.00	16.00	17.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	568,974					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	11,955,324				14.00
15.00	01500	PHARMACY	0	0	239,248			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	719,763,223		16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	32,212	17.00
23.00	02300	PARAMED ED PRGM-LABARATORY ED	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	201,995	993,768	13,310	58,525,079	25,208	30.00
31.00	03100	INTENSIVE CARE UNIT	47,705	441,720	1,842	7,297,502	2,551	31.00
41.00	04100	SUBPROVIDER - IIRF	22,570	51,705	307	5,620,534	2,360	41.00
43.00	04300	NURSERY	16,748	0	0	3,723,575	2,093	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	33,944	4,250,776	45,899	98,806,118	0	50.00
51.00	05100	RECOVERY ROOM	18,611	226,529	210	14,188,587	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	56,323	505,712	4,537	21,855,255	0	52.00
53.00	05300	ANESTHESIOLOGY	0	285,762	28,137	32,315,437	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,227	92,841	2,396	23,913,952	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	7,384	166,804	4,198	4,411,017	0	55.00
56.00	05600	RADIOISOTOPE	0	11,564	5,524	11,377,558	0	56.00
57.00	05700	CT SCAN	10	71,418	7,829	79,805,150	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	35	20,055	542	13,770,222	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	9,358	1,315,351	687	46,454,822	0	59.00
60.00	06000	LABORATORY	0	2,197,030	189	85,135,298	0	60.00
64.00	06400	INTRAVENOUS THERAPY	3,989	13,664	209	1,046,106	0	64.00
65.00	06500	RESPIRATORY THERAPY	156	221,234	1,650	14,331,789	0	65.00
66.00	06600	PHYSICAL THERAPY	0	10,335	63	8,267,833	0	66.00
66.01	03951	CLINICAL NUTRITION	0	0	0	23,661	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	4,654	97	3,714,448	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	755	0	2,100,940	0	68.00
69.00	06900	ELECTROCARDIOLOGY	23,936	170,796	41,541	26,377,877	0	69.00
69.01	06901	CARDIAC REHABILITATION	3,648	2,819	48	777,975	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	566	79	224,900	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	14,582,309	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	9,824,333	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	24,549	89,721	348	67,139,055	0	73.00
74.00	07400	RENAL DIALYSIS	0	11,932	3	2,211,858	0	74.00
76.00	03950	ENDOSCOPY	0	0	0	0	0	76.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	52,214	302,436	76,430	14,028,556	0	90.00
91.00	09100	EMERGENCY	43,515	495,377	3,173	47,911,477	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
102.00	10200	OPICID TREATMENT PROGRAM	0	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	568,917	11,955,324	239,248	719,763,223	32,212	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	57	0	0	0	0	192.00
194.00	07950	OTHER NRB COST CENTER	0	0	0	0	0	194.00
194.01	07951	OTHER NRB COST CENTER	0	0	0	0	0	194.01
194.02	07952	NONREIMBURSABLE COST CENTER	0	0	0	0	0	194.02
194.03	07953	RETAIL PHARMACY	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	3,127,039	712,827	4,883,248	384,245	304,013	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	5.495926	0.059624	20.410821	0.000534	9.437880	203.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0046

Period:
From 01/01/2023
To 12/31/2023

Worksheet B-1

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Cost Center Description		NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TOTAL PATIENT DAYS)	
		13.00	14.00	15.00	16.00	17.00	
204.00	Cost to be allocated (per Wkst. B, Part II)	312,710	8,058	410,998	126,414	108,199	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.549603	0.000674	1.717874	0.000176	3.358966	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: 14-0046

Period:
From 01/01/2023
To 12/31/2023

Worksheet B-1

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Cost Center Description			PARAMED PRGM-LABARATOR Y ED (ASSIGNED TIME)	
			23.00	
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
23.00	02300	PARAMED PRGM-LABARATORY ED	100	23.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	31.00
41.00	04100	SUBPROVIDER - IRF	0	41.00
43.00	04300	NURSERY	0	43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	50.00
51.00	05100	RECOVERY ROOM	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	52.00
53.00	05300	ANESTHESIOLOGY	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	55.00
56.00	05600	RADIOISOTOPE	0	56.00
57.00	05700	CT SCAN	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	59.00
60.00	06000	LABORATORY	100	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
66.01	03951	CLINICAL NUTRITION	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	69.00
69.01	06901	CARDIAC REHABILITATION	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	73.00
74.00	07400	RENAL DIALYSIS	0	74.00
76.00	03950	ENDOSCOPY	0	76.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	78.00
OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	90.00
91.00	09100	EMERGENCY	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		92.00
OTHER REIMBURSABLE COST CENTERS				
102.00	10200	OPICID TREATMENT PROGRAM	0	102.00
SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	100	118.00
NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	190.00
191.00	19100	RESEARCH	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	192.00
194.00	07950	OTHER NRB COST CENTER	0	194.00
194.01	07951	OTHER NRB COST CENTER	0	194.01
194.02	07952	NONREIMBURSABLE COST CENTER	0	194.02
194.03	07953	RETAIL PHARMACY	0	194.03
200.00		Cross Foot Adjustments		200.00
201.00		Negative Cost Centers		201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	55,605	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	556.050000	203.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0046

Period:
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Cost Center Description		PARAMETER PRGM-LABORATORY ED (ASSIGNED TIME)		
		23.00		
204.00	Cost to be allocated (per Wkst. B, Part II)	19,930		204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	199.300000		205.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)	0		206.00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)	0.000000		207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0046

Period:
From 01/01/2023
To 12/31/2023Worksheet C
Part I
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			Title XVIII		Hospital	PPS
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	40,108,622		40,108,622	26,780	40,135,402
31.00	03100 INTENSIVE CARE UNIT	6,759,636		6,759,636	26,278	6,785,914
41.00	04100 SUBPROVIDER - IRF	5,146,838		5,146,838	60,675	5,207,513
43.00	04300 NURSERY	2,308,707		2,308,707	0	2,308,707
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	11,935,665		11,935,665	0	11,935,665
51.00	05100 RECOVERY ROOM	1,889,372		1,889,372	0	1,889,372
52.00	05200 DELIVERY ROOM & LABOR ROOM	7,164,111		7,164,111	0	7,164,111
53.00	05300 ANESTHESIOLOGY	956,280		956,280	0	956,280
54.00	05400 RADIOLOGY-DIAGNOSTIC	5,424,523		5,424,523	0	5,424,523
55.00	05500 RADIOLOGY-THERAPEUTIC	2,983,360		2,983,360	0	2,983,360
56.00	05600 RADIOISOTOPE	1,032,250		1,032,250	0	1,032,250
57.00	05700 CT SCAN	1,998,496		1,998,496	0	1,998,496
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	960,492		960,492	0	960,492
59.00	05900 CARDIAC CATHETERIZATION	3,265,849		3,265,849	0	3,265,849
60.00	06000 LABORATORY	7,600,790		7,600,790	0	7,600,790
64.00	06400 INTRAVENOUS THERAPY	560,120		560,120	0	560,120
65.00	06500 RESPIRATORY THERAPY	4,038,766	0	4,038,766	0	4,038,766
66.00	06600 PHYSICAL THERAPY	2,499,804	0	2,499,804	0	2,499,804
66.01	03951 CLINICAL NUTRITION	292,379	0	292,379	0	292,379
67.00	06700 OCCUPATIONAL THERAPY	1,312,562	0	1,312,562	0	1,312,562
68.00	06800 SPEECH PATHOLOGY	679,788	0	679,788	0	679,788
69.00	06900 ELECTROCARDIOLOGY	6,928,262		6,928,262	123,951	7,052,213
69.01	06901 CARDIAC REHABILITATION	302,994		302,994	6,746	309,740
70.00	07000 ELECTROENCEPHALOGRAPHY	177,980		177,980	4,062	182,042
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	13,096,053		13,096,053	0	13,096,053
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	5,621,193		5,621,193	0	5,621,193
73.00	07300 DRUGS CHARGED TO PATIENTS	16,724,318		16,724,318	0	16,724,318
74.00	07400 RENAL DIALYSIS	1,213,531		1,213,531	36,943	1,250,474
76.00	03950 ENDOSCOPY	0		0	0	0
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0		0	0	0
78.00	07800 CAR T-CELL IMMUNOTHERAPY	0		0	0	0
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	11,018,980		11,018,980	0	11,018,980
91.00	09100 EMERGENCY	7,963,119		7,963,119	59,209	8,022,328
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1,549,089		1,549,089		1,549,089
OTHER REIMBURSABLE COST CENTERS						
102.00	10200 OPIOID TREATMENT PROGRAM	0		0		0
200.00	Subtotal (see instructions)	173,513,929	0	173,513,929	344,644	173,858,573
201.00	Less Observation Beds	1,549,089		1,549,089		1,549,089
202.00	Total (see instructions)	171,964,840	0	171,964,840	344,644	172,309,484

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0046

Period:
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Part I
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			Title XVIII			Hospital	PPS	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
			Inpatient	Outpatient	Total (col. 6 + col. 7)			
			6.00	7.00	8.00		9.00	
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	56,892,325		56,892,325			30.00
31.00	03100	INTENSIVE CARE UNIT	7,297,502		7,297,502			31.00
41.00	04100	SUBPROVIDER - IRF	5,620,534		5,620,534			41.00
43.00	04300	NURSERY	3,723,575		3,723,575			43.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	46,044,526	52,761,592	98,806,118	0.120799	0.000000	50.00
51.00	05100	RECOVERY ROOM	4,948,273	9,240,314	14,188,587	0.133161	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	19,049,215	2,806,040	21,855,255	0.327798	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	16,574,687	15,740,750	32,315,437	0.029592	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,585,562	17,328,390	23,913,952	0.226835	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	1,536,705	2,874,312	4,411,017	0.676343	0.000000	55.00
56.00	05600	RADIOISOTOPE	2,604,226	8,773,332	11,377,558	0.090727	0.000000	56.00
57.00	05700	CT SCAN	26,180,795	53,624,355	79,805,150	0.025042	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	3,594,773	10,175,449	13,770,222	0.069751	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	23,861,854	22,592,968	46,454,822	0.070302	0.000000	59.00
60.00	06000	LABORATORY	37,684,199	47,451,099	85,135,298	0.089279	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	2,754	1,043,352	1,046,106	0.535433	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	12,638,313	1,693,476	14,331,789	0.281805	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	4,434,259	3,833,574	8,267,833	0.302353	0.000000	66.00
66.01	03951	CLINICAL NUTRITION	186	23,475	23,661	12.357001	0.000000	66.01
67.00	06700	OCCUPATIONAL THERAPY	2,559,820	1,154,628	3,714,448	0.353367	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	1,272,265	828,675	2,100,940	0.323564	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	11,741,574	14,636,303	26,377,877	0.262654	0.000000	69.00
69.01	06901	CARDIAC REHABILITATION	1,008	776,967	777,975	0.389465	0.000000	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	210,600	14,300	224,900	0.791374	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	10,504,408	4,077,901	14,582,309	0.898078	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,035,059	3,789,274	9,824,333	0.572170	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	26,953,187	40,185,868	67,139,055	0.249100	0.000000	73.00
74.00	07400	RENAL DIALYSIS	2,168,357	43,501	2,211,858	0.548648	0.000000	74.00
76.00	03950	ENDOSCOPY	0	0	0	0.000000	0.000000	76.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0.000000	0.000000	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0.000000	0.000000	78.00
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	326,403	13,702,153	14,028,556	0.785468	0.000000	90.00
91.00	09100	EMERGENCY	13,703,079	34,208,398	47,911,477	0.166205	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	365,312	1,267,442	1,632,754	0.948758	0.000000	92.00
	OTHER REIMBURSABLE COST CENTERS							
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0			102.00
200.00		Subtotal (see instructions)	355,115,335	364,647,888	719,763,223			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	355,115,335	364,647,888	719,763,223			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0046

Period:
From 01/01/2023
To 12/31/2023Worksheet C
Part I
Date/Time Prepared:
5/21/2024 10:06 am

Cost Center Description			PPS Inpatient Ratio	Title XVIII	Hospital	PPS
			11.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
41.00	04100	SUBPROVIDER - IRF				41.00
43.00	04300	NURSERY				43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.120799			50.00
51.00	05100	RECOVERY ROOM	0.133161			51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.327798			52.00
53.00	05300	ANESTHESIOLOGY	0.029592			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.226835			54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.676343			55.00
56.00	05600	RADIOISOTOPE	0.090727			56.00
57.00	05700	CT SCAN	0.025042			57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.069751			58.00
59.00	05900	CARDIAC CATHETERIZATION	0.070302			59.00
60.00	06000	LABORATORY	0.089279			60.00
64.00	06400	INTRAVENOUS THERAPY	0.535433			64.00
65.00	06500	RESPIRATORY THERAPY	0.281805			65.00
66.00	06600	PHYSICAL THERAPY	0.302353			66.00
66.01	03951	CLINICAL NUTRITION	12.357001			66.01
67.00	06700	OCCUPATIONAL THERAPY	0.353367			67.00
68.00	06800	SPEECH PATHOLOGY	0.323564			68.00
69.00	06900	ELECTROCARDIOLOGY	0.267353			69.00
69.01	06901	CARDIAC REHABILITATION	0.398136			69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.809435			70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.898078			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.572170			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.249100			73.00
74.00	07400	RENAL DIALYSIS	0.565350			74.00
76.00	03950	ENDOSCOPY	0.000000			76.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000			77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000			78.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.785468			90.00
91.00	09100	EMERGENCY	0.167441			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.948758			92.00
OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM				102.00
200.00		Subtotal (see instructions)				200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)				202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0046

Period:
From 01/01/2023
To 12/31/2023Worksheet C
Part I
Date/Time Prepared:
5/21/2024 10:06 am

				Title XIX		Hospital		PPS	
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	40,108,622		40,108,622	26,780	40,135,402	30.00	
31.00	03100	INTENSIVE CARE UNIT	6,759,636		6,759,636	26,278	6,785,914	31.00	
41.00	04100	SUBPROVIDER - IRF	5,146,838		5,146,838	60,675	5,207,513	41.00	
43.00	04300	NURSERY	2,308,707		2,308,707	0	2,308,707	43.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	11,935,665		11,935,665	0	11,935,665	50.00	
51.00	05100	RECOVERY ROOM	1,889,372		1,889,372	0	1,889,372	51.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	7,164,111		7,164,111	0	7,164,111	52.00	
53.00	05300	ANESTHESIOLOGY	956,280		956,280	0	956,280	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,424,523		5,424,523	0	5,424,523	54.00	
55.00	05500	RADIOLOGY-THERAPEUTIC	2,983,360		2,983,360	0	2,983,360	55.00	
56.00	05600	RADIOISOTOPE	1,032,250		1,032,250	0	1,032,250	56.00	
57.00	05700	CT SCAN	1,998,496		1,998,496	0	1,998,496	57.00	
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	960,492		960,492	0	960,492	58.00	
59.00	05900	CARDIAC CATHETERIZATION	3,265,849		3,265,849	0	3,265,849	59.00	
60.00	06000	LABORATORY	7,600,790		7,600,790	0	7,600,790	60.00	
64.00	06400	INTRAVENOUS THERAPY	560,120		560,120	0	560,120	64.00	
65.00	06500	RESPIRATORY THERAPY	4,038,766	0	4,038,766	0	4,038,766	65.00	
66.00	06600	PHYSICAL THERAPY	2,499,804	0	2,499,804	0	2,499,804	66.00	
66.01	03951	CLINICAL NUTRITION	292,379	0	292,379	0	292,379	66.01	
67.00	06700	OCCUPATIONAL THERAPY	1,312,562	0	1,312,562	0	1,312,562	67.00	
68.00	06800	SPEECH PATHOLOGY	679,788	0	679,788	0	679,788	68.00	
69.00	06900	ELECTROCARDIOLOGY	6,928,262		6,928,262	123,951	7,052,213	69.00	
69.01	06901	CARDIAC REHABILITATION	302,994		302,994	6,746	309,740	69.01	
70.00	07000	ELECTROENCEPHALOGRAPHY	177,980		177,980	4,062	182,042	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	13,096,053		13,096,053	0	13,096,053	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,621,193		5,621,193	0	5,621,193	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	16,724,318		16,724,318	0	16,724,318	73.00	
74.00	07400	RENAL DIALYSIS	1,213,531		1,213,531	36,943	1,250,474	74.00	
76.00	03950	ENDOSCOPY	0		0	0	0	76.00	
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0		0	0	0	77.00	
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0		0	0	0	78.00	
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	11,018,980		11,018,980	0	11,018,980	90.00	
91.00	09100	EMERGENCY	7,963,119		7,963,119	59,209	8,022,328	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,549,089		1,549,089		1,549,089	92.00	
OTHER REIMBURSABLE COST CENTERS									
102.00	10200	OPIOID TREATMENT PROGRAM	0		0		0	102.00	
200.00		Subtotal (see instructions)	173,513,929	0	173,513,929	344,644	173,858,573	200.00	
201.00		Less Observation Beds	1,549,089		1,549,089		1,549,089	201.00	
202.00		Total (see instructions)	171,964,840	0	171,964,840	344,644	172,309,484	202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0046

Period:
From 01/01/2023
To 12/31/2023Worksheet C
Part I
Date/Time Prepared:
5/21/2024 10:06 am

			Title XIX			Hospital	PPS		
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
			Inpatient	Outpatient	Total (col. 6 + col. 7)				
			6.00	7.00	8.00	9.00	10.00		
	INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	56,892,325		56,892,325			30.00	
31.00	03100	INTENSIVE CARE UNIT	7,297,502		7,297,502			31.00	
41.00	04100	SUBPROVIDER - IRF	5,620,534		5,620,534			41.00	
43.00	04300	NURSERY	3,723,575		3,723,575			43.00	
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	46,044,526	52,761,592	98,806,118	0.120799	0.000000	50.00	
51.00	05100	RECOVERY ROOM	4,948,273	9,240,314	14,188,587	0.133161	0.000000	51.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	19,049,215	2,806,040	21,855,255	0.327798	0.000000	52.00	
53.00	05300	ANESTHESIOLOGY	16,574,687	15,740,750	32,315,437	0.029592	0.000000	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,585,562	17,328,390	23,913,952	0.226835	0.000000	54.00	
55.00	05500	RADIOLOGY-THERAPEUTIC	1,536,705	2,874,312	4,411,017	0.676343	0.000000	55.00	
56.00	05600	RADIOISOTOPE	2,604,226	8,773,332	11,377,558	0.090727	0.000000	56.00	
57.00	05700	CT SCAN	26,180,795	53,624,355	79,805,150	0.025042	0.000000	57.00	
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	3,594,773	10,175,449	13,770,222	0.069751	0.000000	58.00	
59.00	05900	CARDIAC CATHETERIZATION	23,861,854	22,592,968	46,454,822	0.070302	0.000000	59.00	
60.00	06000	LABORATORY	37,684,199	47,451,099	85,135,298	0.089279	0.000000	60.00	
64.00	06400	INTRAVENOUS THERAPY	2,754	1,043,352	1,046,106	0.535433	0.000000	64.00	
65.00	06500	RESPIRATORY THERAPY	12,638,313	1,693,476	14,331,789	0.281805	0.000000	65.00	
66.00	06600	PHYSICAL THERAPY	4,434,259	3,833,574	8,267,833	0.302353	0.000000	66.00	
66.01	03951	CLINICAL NUTRITION	186	23,475	23,661	12.357001	0.000000	66.01	
67.00	06700	OCCUPATIONAL THERAPY	2,559,820	1,154,628	3,714,448	0.353367	0.000000	67.00	
68.00	06800	SPEECH PATHOLOGY	1,272,265	828,675	2,100,940	0.323564	0.000000	68.00	
69.00	06900	ELECTROCARDIOLOGY	11,741,574	14,636,303	26,377,877	0.262654	0.000000	69.00	
69.01	06901	CARDIAC REHABILITATION	1,008	776,967	777,975	0.389465	0.000000	69.01	
70.00	07000	ELECTROENCEPHALOGRAPHY	210,600	14,300	224,900	0.791374	0.000000	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	10,504,408	4,077,901	14,582,309	0.898078	0.000000	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,035,059	3,789,274	9,824,333	0.572170	0.000000	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	26,953,187	40,185,868	67,139,055	0.249100	0.000000	73.00	
74.00	07400	RENAL DIALYSIS	2,168,357	43,501	2,211,858	0.548648	0.000000	74.00	
76.00	03950	ENDOSCOPY	0	0	0	0.000000	0.000000	76.00	
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0.000000	0.000000	77.00	
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0.000000	0.000000	78.00	
	OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	326,403	13,702,153	14,028,556	0.785468	0.000000	90.00	
91.00	09100	EMERGENCY	13,703,079	34,208,398	47,911,477	0.166205	0.000000	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	365,312	1,267,442	1,632,754	0.948758	0.000000	92.00	
	OTHER REIMBURSABLE COST CENTERS								
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0			102.00	
200.00		Subtotal (see instructions)	355,115,335	364,647,888	719,763,223			200.00	
201.00		Less Observation Beds						201.00	
202.00		Total (see instructions)	355,115,335	364,647,888	719,763,223			202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0046

Period:
From 01/01/2023
To 12/31/2023Worksheet C
Part I
Date/Time Prepared:
5/21/2024 10:06 am

Cost Center Description			PPS Inpatient Ratio	Title XIX	Hospital	PPS
			11.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
41.00	04100	SUBPROVIDER - IRF				41.00
43.00	04300	NURSERY				43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.120799			50.00
51.00	05100	RECOVERY ROOM	0.133161			51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.327798			52.00
53.00	05300	ANESTHESIOLOGY	0.029592			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.226835			54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.676343			55.00
56.00	05600	RADIOISOTOPE	0.090727			56.00
57.00	05700	CT SCAN	0.025042			57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.069751			58.00
59.00	05900	CARDIAC CATHETERIZATION	0.070302			59.00
60.00	06000	LABORATORY	0.089279			60.00
64.00	06400	INTRAVENOUS THERAPY	0.535433			64.00
65.00	06500	RESPIRATORY THERAPY	0.281805			65.00
66.00	06600	PHYSICAL THERAPY	0.302353			66.00
66.01	03951	CLINICAL NUTRITION	12.357001			66.01
67.00	06700	OCCUPATIONAL THERAPY	0.353367			67.00
68.00	06800	SPEECH PATHOLOGY	0.323564			68.00
69.00	06900	ELECTROCARDIOLOGY	0.267353			69.00
69.01	06901	CARDIAC REHABILITATION	0.398136			69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.809435			70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.898078			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.572170			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.249100			73.00
74.00	07400	RENAL DIALYSIS	0.565350			74.00
76.00	03950	ENDOSCOPY	0.000000			76.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000			77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000			78.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.785468			90.00
91.00	09100	EMERGENCY	0.167441			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.948758			92.00
OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM				102.00
200.00		Subtotal (see instructions)				200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)				202.00

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

Provider CCN: 14-0046

Period:
From 01/01/2023
To 12/31/2023Worksheet C
Part II
Date/Time Prepared:
5/21/2024 10:06 am

Cost Center Description			Title XIX			Hospital	PPS	
			Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
			1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	11,935,665	1,669,855	10,265,810	0	0	50.00
51.00	05100	RECOVERY ROOM	1,889,372	29,811	1,859,561	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	7,164,111	436,238	6,727,873	0	0	52.00
53.00	05300	ANESTHESIOLOGY	956,280	88,565	867,715	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,424,523	791,591	4,632,932	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	2,983,360	155,287	2,828,073	0	0	55.00
56.00	05600	RADIOISOTOPE	1,032,250	18,235	1,014,015	0	0	56.00
57.00	05700	CT SCAN	1,998,496	229,304	1,769,192	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	960,492	215,946	744,546	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	3,265,849	329,349	2,936,500	0	0	59.00
60.00	06000	LABORATORY	7,600,790	410,571	7,190,219	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	560,120	48,809	511,311	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	4,038,766	241,931	3,796,835	0	0	65.00
66.00	06600	PHYSICAL THERAPY	2,499,804	139,336	2,360,468	0	0	66.00
66.01	03951	CLINICAL NUTRITION	292,379	2,767	289,612	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	1,312,562	117,661	1,194,901	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	679,788	27,966	651,822	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	6,928,262	891,064	6,037,198	0	0	69.00
69.01	06901	CARDIAC REHABILITATION	302,994	12,086	290,908	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	177,980	41,415	136,565	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	13,096,053	69,404	13,026,649	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,621,193	30,408	5,590,785	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	16,724,318	120,813	16,603,505	0	0	73.00
74.00	07400	RENAL DIALYSIS	1,213,531	6,589	1,206,942	0	0	74.00
76.00	03950	ENDOSCOPY	0	0	0	0	0	76.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	11,018,980	1,416,970	9,602,010	0	0	90.00
91.00	09100	EMERGENCY	7,963,119	582,600	7,380,519	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,549,089	100,121	1,448,968	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
200.00		Subtotal (sum of lines 50 thru 199)	119,190,126	8,224,692	110,965,434	0	0	200.00
201.00		Less Observation Beds	1,549,089	100,121	1,448,968	0	0	201.00
202.00		Total (line 200 minus line 201)	117,641,037	8,124,571	109,516,466	0	0	202.00

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

Provider CCN: 14-0046

Period:
From 01/01/2023
To 12/31/2023Worksheet C
Part II
Date/Time Prepared:
5/21/2024 10:06 am

Cost Center Description				Title XIX		Hospital	PPS
				Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)	
				6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM		11,935,665	98,806,118	0.120799	50.00
51.00	05100	RECOVERY ROOM		1,889,372	14,188,587	0.133161	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		7,164,111	21,855,255	0.327798	52.00
53.00	05300	ANESTHESIOLOGY		956,280	32,315,437	0.029592	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		5,424,523	23,913,952	0.226835	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC		2,983,360	4,411,017	0.676343	55.00
56.00	05600	RADIOISOTOPE		1,032,250	11,377,558	0.090727	56.00
57.00	05700	CT SCAN		1,998,496	79,805,150	0.025042	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)		960,492	13,770,222	0.069751	58.00
59.00	05900	CARDIAC CATHETERIZATION		3,265,849	46,454,822	0.070302	59.00
60.00	06000	LABORATORY		7,600,790	85,135,298	0.089279	60.00
64.00	06400	INTRAVENOUS THERAPY		560,120	1,046,106	0.535433	64.00
65.00	06500	RESPIRATORY THERAPY		4,038,766	14,331,789	0.281805	65.00
66.00	06600	PHYSICAL THERAPY		2,499,804	8,267,833	0.302353	66.00
66.01	03951	CLINICAL NUTRITION		292,379	23,661	12.357001	66.01
67.00	06700	OCCUPATIONAL THERAPY		1,312,562	3,714,448	0.353367	67.00
68.00	06800	SPEECH PATHOLOGY		679,788	2,100,940	0.323564	68.00
69.00	06900	ELECTROCARDIOLOGY		6,928,262	26,377,877	0.262654	69.00
69.01	06901	CARDIAC REHABILITATION		302,994	777,975	0.389465	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY		177,980	224,900	0.791374	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		13,096,053	14,582,309	0.898078	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		5,621,193	9,824,333	0.572170	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		16,724,318	67,139,055	0.249100	73.00
74.00	07400	RENAL DIALYSIS		1,213,531	2,211,858	0.548648	74.00
76.00	03950	ENDOSCOPY		0	0	0.000000	76.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION		0	0	0.000000	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY		0	0	0.000000	78.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC		11,018,980	14,028,556	0.785468	90.00
91.00	09100	EMERGENCY		7,963,119	47,911,477	0.166205	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		1,549,089	1,632,754	0.948758	92.00
OTHER REIMBURSABLE COST CENTERS							
102.00	10200	OPIOID TREATMENT PROGRAM		0	0	0.000000	102.00
200.00		Subtotal (sum of lines 50 thru 199)		119,190,126	646,229,287		200.00
201.00		Less Observation Beds		1,549,089	0		201.00
202.00		Total (line 200 minus line 201)		117,641,037	646,229,287		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-0046

Period:
From 01/01/2023
To 12/31/2023Worksheet D
Part I
Date/Time Prepared:
5/21/2024 10:06 am

Cost Center Description			Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Hospital Total Patient Days	PPS Per Diem (col. 3 / col. 4)	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	ADULTS & PEDIATRICS	2,594,051	0	2,594,051	26,220	98.93	30.00	
31.00	INTENSIVE CARE UNIT	667,354		667,354	2,551	261.60	31.00	
41.00	SUBPROVIDER - IRF	400,910	0	400,910	2,360	169.88	41.00	
43.00	NURSERY	84,644		84,644	2,093	40.44	43.00	
200.00	Total (lines 30 through 199)	3,746,959		3,746,959	33,224		200.00	
Cost Center Description			Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
			6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	ADULTS & PEDIATRICS	11,378	1,125,626					30.00
31.00	INTENSIVE CARE UNIT	1,069	279,650					31.00
41.00	SUBPROVIDER - IRF	1,236	209,972					41.00
43.00	NURSERY	0	0					43.00
200.00	Total (lines 30 through 199)	13,683	1,615,248					200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0046

Period:
From 01/01/2023
To 12/31/2023Worksheet D
Part II
Date/Time Prepared:
5/21/2024 10:06 am

Cost Center Description		Title XVIII		Hospital		PPS	
		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	1,669,855	98,806,118	0.016900	22,455,554	379,499	50.00
51.00	05100 RECOVERY ROOM	29,811	14,188,587	0.002101	2,146,321	4,509	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	436,238	21,855,255	0.019960	15,642	312	52.00
53.00	05300 ANESTHESIOLOGY	88,565	32,315,437	0.002741	3,462,665	9,491	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	791,591	23,913,952	0.033102	3,242,553	107,335	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	155,287	4,411,017	0.035204	420	15	55.00
56.00	05600 RADIOISOTOPE	18,235	11,377,558	0.001603	850,094	1,363	56.00
57.00	05700 CT SCAN	229,304	79,805,150	0.002873	11,617,631	33,377	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	215,946	13,770,222	0.015682	1,406,404	22,055	58.00
59.00	05900 CARDIAC CATHETERIZATION	329,349	46,454,822	0.007090	0	0	59.00
60.00	06000 LABORATORY	410,571	85,135,298	0.004823	15,509,252	74,801	60.00
64.00	06400 INTRAVENOUS THERAPY	48,809	1,046,106	0.046658	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	241,931	14,331,789	0.016881	5,003,181	84,459	65.00
66.00	06600 PHYSICAL THERAPY	139,336	8,267,833	0.016853	2,137,262	36,019	66.00
66.01	03951 CLINICAL NUTRITION	2,767	23,661	0.116943	0	0	66.01
67.00	06700 OCCUPATIONAL THERAPY	117,661	3,714,448	0.031677	1,111,018	35,194	67.00
68.00	06800 SPEECH PATHOLOGY	27,966	2,100,940	0.013311	409,523	5,451	68.00
69.00	06900 ELECTROCARDIOLOGY	891,064	26,377,877	0.033781	11,712,856	395,672	69.00
69.01	06901 CARDIAC REHABILITATION	12,086	777,975	0.015535	0	0	69.01
70.00	07000 ELECTROENCEPHALOGRAPHY	41,415	224,900	0.184149	91,000	16,758	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	69,404	14,582,309	0.004759	4,519,267	21,507	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	30,408	9,824,333	0.003095	2,599,919	8,047	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	120,813	67,139,055	0.001799	11,118,638	20,002	73.00
74.00	07400 RENAL DIALYSIS	6,589	2,211,858	0.002979	1,233,487	3,675	74.00
76.00	03950 ENDOSCOPY	0	0	0.000000	0	0	76.00
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0	0	0.000000	0	0	77.00
78.00	07800 CAR T-CELL IMMUNOTHERAPY	0	0	0.000000	0	0	78.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	1,416,970	14,028,556	0.101006	1,104	112	90.00
91.00	09100 EMERGENCY	582,600	47,911,477	0.012160	6,464,687	78,611	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	100,121	1,632,754	0.061320	134,269	8,233	92.00
200.00	Total (lines 50 through 199)	8,224,692	646,229,287		107,242,747	1,346,497	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-0046		Period: From 01/01/2023 To 12/31/2023		Worksheet D Part III Date/Time Prepared: 5/21/2024 10:06 am	
					Title XVIII		Hospital		PPS	
Cost Center Description			Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost			
			1A	1.00	2A	2.00	3.00			
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00		
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00		
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00		
43.00	04300	NURSERY	0	0	0	0	0	43.00		
200.00		Total (lines 30 through 199)	0	0	0	0	0	200.00		
Cost Center Description			Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days			
			4.00	5.00	6.00	7.00	8.00			
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	0	0	26,220	0.00	11,378	30.00		
31.00	03100	INTENSIVE CARE UNIT	0	0	2,551	0.00	1,069	31.00		
41.00	04100	SUBPROVIDER - IRF	0	0	2,360	0.00	1,236	41.00		
43.00	04300	NURSERY	0	0	2,093	0.00	0	43.00		
200.00		Total (lines 30 through 199)	0	0	33,224		13,683	200.00		
Cost Center Description			Inpatient Program Pass-Through Cost (col. 7 x col. 8)							
			9.00							
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	0						30.00	
31.00	03100	INTENSIVE CARE UNIT	0						31.00	
41.00	04100	SUBPROVIDER - IRF	0						41.00	
43.00	04300	NURSERY	0						43.00	
200.00		Total (lines 30 through 199)	0						200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0046

Period:
From 01/01/2023
To 12/31/2023Worksheet D
Part IV
Date/Time Prepared:
5/21/2024 10:06 am

Cost Center Description			Title XVIII			Hospital	PPS	
			Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	55,605	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
66.01	03951	CLINICAL NUTRITION	0	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	CARDIAC REHABILITATION	0	0	0	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	ENDOSCOPY	0	0	0	0	0	76.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	55,605	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0046

Period:
From 01/01/2023
To 12/31/2023Worksheet D
Part IV
Date/Time Prepared:
5/21/2024 10:06 am

			Title XVIII		Hospital	PPS		
Cost Center Description			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	98,806,118	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	14,188,587	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	21,855,255	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	32,315,437	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	23,913,952	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	4,411,017	0.000000	55.00
56.00	05600	RADIOISOTOPE	0	0	0	11,377,558	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	79,805,150	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	13,770,222	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	46,454,822	0.000000	59.00
60.00	06000	LABORATORY	0	55,605	55,605	85,135,298	0.000653	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	1,046,106	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	14,331,789	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	8,267,833	0.000000	66.00
66.01	03951	CLINICAL NUTRITION	0	0	0	23,661	0.000000	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	3,714,448	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	2,100,940	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	26,377,877	0.000000	69.00
69.01	06901	CARDIAC REHABILITATION	0	0	0	777,975	0.000000	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	224,900	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	14,582,309	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	9,824,333	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	67,139,055	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	2,211,858	0.000000	74.00
76.00	03950	ENDOSCOPY	0	0	0	0	0.000000	76.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0.000000	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0.000000	78.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	14,028,556	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	47,911,477	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	1,632,754	0.000000	92.00
200.00		Total (lines 50 through 199)	0	55,605	55,605	646,229,287		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0046		Period: From 01/01/2023 To 12/31/2023		Worksheet D Part IV Date/Time Prepared: 5/21/2024 10:06 am	
				Title XVIII		Hospital		PPS	
Cost Center Description				Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
				9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0.000000	22,455,554	0	17,270,338	0	50.00
51.00	05100	RECOVERY ROOM		0.000000	2,146,321	0	3,263,982	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0.000000	15,642	0	4,572	0	52.00
53.00	05300	ANESTHESIOLOGY		0.000000	3,462,665	0	2,791,400	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0.000000	3,242,553	0	7,780,702	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC		0.000000	420	0	336,970	0	55.00
56.00	05600	RADIOISOTOPE		0.000000	850,094	0	2,398,541	0	56.00
57.00	05700	CT SCAN		0.000000	11,617,631	0	16,613,573	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)		0.000000	1,406,404	0	3,599,848	0	58.00
59.00	05900	CARDIAC CATHETERIZATION		0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY		0.000653	15,509,252	10,128	7,561,051	4,937	60.00
64.00	06400	INTRAVENOUS THERAPY		0.000000	0	0	453,374	0	64.00
65.00	06500	RESPIRATORY THERAPY		0.000000	5,003,181	0	79,111	0	65.00
66.00	06600	PHYSICAL THERAPY		0.000000	2,137,262	0	38,868	0	66.00
66.01	03951	CLINICAL NUTRITION		0.000000	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY		0.000000	1,111,018	0	6,000	0	67.00
68.00	06800	SPEECH PATHOLOGY		0.000000	409,523	0	5,840	0	68.00
69.00	06900	ELECTROCARDIOLOGY		0.000000	11,712,856	0	13,558,365	0	69.00
69.01	06901	CARDIAC REHABILITATION		0.000000	0	0	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY		0.000000	91,000	0	2,600	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		0.000000	4,519,267	0	1,410,642	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0.000000	2,599,919	0	1,565,632	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0.000000	11,118,638	0	18,498,340	0	73.00
74.00	07400	RENAL DIALYSIS		0.000000	1,233,487	0	11,215	0	74.00
76.00	03950	ENDOSCOPY		0.000000	0	0	0	0	76.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION		0.000000	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY		0.000000	0	0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC		0.000000	1,104	0	489,937	0	90.00
91.00	09100	EMERGENCY		0.000000	6,464,687	0	9,218,772	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0.000000	134,269	0	186,289	0	92.00
200.00		Total (lines 50 through 199)			107,242,747	10,128	107,145,962	4,937	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0046

Period:
From 01/01/2023
To 12/31/2023Worksheet D
Part V
Date/Time Prepared:
5/21/2024 10:06 am

			Title XVIII		Hospital		PPS	
Cost Center Description			Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs		
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0.120799	17,270,338	0	0	2,086,240	50.00
51.00	05100	RECOVERY ROOM	0.133161	3,263,982	0	0	434,635	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.327798	4,572	0	0	1,499	52.00
53.00	05300	ANESTHESIOLOGY	0.029592	2,791,400	0	0	82,603	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.226835	7,780,702	0	0	1,764,936	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.676343	336,970	0	0	227,907	55.00
56.00	05600	RADIOISOTOPE	0.090727	2,398,541	0	0	217,612	56.00
57.00	05700	CT SCAN	0.025042	16,613,573	0	0	416,037	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.069751	3,599,848	0	0	251,093	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.070302	0	0	0	0	59.00
60.00	06000	LABORATORY	0.089279	7,561,051	0	0	675,043	60.00
64.00	06400	INTRAVENOUS THERAPY	0.535433	453,374	0	0	242,751	64.00
65.00	06500	RESPIRATORY THERAPY	0.281805	79,111	0	0	22,294	65.00
66.00	06600	PHYSICAL THERAPY	0.302353	38,868	0	0	11,752	66.00
66.01	03951	CLINICAL NUTRITION	12.357001	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0.353367	6,000	0	0	2,120	67.00
68.00	06800	SPEECH PATHOLOGY	0.323564	5,840	0	0	1,890	68.00
69.00	06900	ELECTROCARDIOLOGY	0.262654	13,558,365	0	0	3,561,159	69.00
69.01	06901	CARDIAC REHABILITATION	0.389465	0	0	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.791374	2,600	0	0	2,058	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.898078	1,410,642	0	0	1,266,867	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.572170	1,565,632	0	0	895,808	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.249100	18,498,340	492	29,194	4,607,936	73.00
74.00	07400	RENAL DIALYSIS	0.548648	11,215	0	0	6,153	74.00
76.00	03950	ENDOSCOPY	0.000000	0	0	0	0	76.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000	0	0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0.785468	489,937	0	0	384,830	90.00
91.00	09100	EMERGENCY	0.166205	9,218,772	0	0	1,532,206	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.948758	186,289	0	0	176,743	92.00
200.00		Subtotal (see instructions)		107,145,962	492	29,194	18,872,172	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		107,145,962	492	29,194	18,872,172	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0046

Period:
From 01/01/2023
To 12/31/2023Worksheet D
Part V
Date/Time Prepared:
5/21/2024 10:06 am

			Title XVIII		Hospital	PPS
	Cost Center Description	Costs				
		Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)			
		6.00	7.00			
	ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0		55.00
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	0	0		60.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
66.01	03951	CLINICAL NUTRITION	0	0		66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
69.01	06901	CARDIAC REHABILITATION	0	0		69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	123	7,272		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.00	03950	ENDOSCOPY	0	0		76.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0		77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0		78.00
	OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00		Subtotal (see instructions)	123	7,272		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	123	7,272		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS				Provider CCN: 14-0046	Period: From 01/01/2023 To 12/31/2023	Worksheet D Part II Date/Time Prepared: 5/21/2024 10:06 am		
				Component CCN: 14-T046				
				Title XVIII		Subprovider - IRF	PPS	
Cost Center Description			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,669,855	98,806,118	0.016900	2,247	38	50.00
51.00	05100	RECOVERY ROOM	29,811	14,188,587	0.002101	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	436,238	21,855,255	0.019960	0	0	52.00
53.00	05300	ANESTHESIOLOGY	88,565	32,315,437	0.002741	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	791,591	23,913,952	0.033102	22,912	758	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	155,287	4,411,017	0.035204	0	0	55.00
56.00	05600	RADIOISOTOPE	18,235	11,377,558	0.001603	7,188	12	56.00
57.00	05700	CT SCAN	229,304	79,805,150	0.002873	37,052	106	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	215,946	13,770,222	0.015682	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	329,349	46,454,822	0.007090	0	0	59.00
60.00	06000	LABORATORY	410,571	85,135,298	0.004823	256,381	1,237	60.00
64.00	06400	INTRAVENOUS THERAPY	48,809	1,046,106	0.046658	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	241,931	14,331,789	0.016881	195,018	3,292	65.00
66.00	06600	PHYSICAL THERAPY	139,336	8,267,833	0.016853	696,601	11,740	66.00
66.01	03951	CLINICAL NUTRITION	2,767	23,661	0.116943	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	117,661	3,714,448	0.031677	700,683	22,196	67.00
68.00	06800	SPEECH PATHOLOGY	27,966	2,100,940	0.013311	258,020	3,435	68.00
69.00	06900	ELECTROCARDIOLOGY	891,064	26,377,877	0.033781	13,213	446	69.00
69.01	06901	CARDIAC REHABILITATION	12,086	777,975	0.015535	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	41,415	224,900	0.184149	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	69,404	14,582,309	0.004759	82,485	393	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	30,408	9,824,333	0.003095	3,402	11	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	120,813	67,139,055	0.001799	195,496	352	73.00
74.00	07400	RENAL DIALYSIS	6,589	2,211,858	0.002979	24,092	72	74.00
76.00	03950	ENDOSCOPY	0	0	0.000000	0	0	76.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0.000000	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0.000000	0	0	78.00
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	1,416,970	14,028,556	0.101006	0	0	90.00
91.00	09100	EMERGENCY	582,600	47,911,477	0.012160	53,174	647	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,632,754	0.000000	0	0	92.00
200.00		Total (lines 50 through 199)	8,124,571	646,229,287		2,547,964	44,735	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0046 Component CCN: 14-T046		Period: From 01/01/2023 To 12/31/2023		Worksheet D Part IV Date/Time Prepared: 5/21/2024 10:06 am	
				Title XVIII		Subprovider - IRF		PPS	
Cost Center Description				Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
				1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM		0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY		0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC		0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE		0	0	0	0	0	56.00
57.00	05700	CT SCAN		0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)		0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION		0	0	0	0	0	59.00
60.00	06000	LABORATORY		0	0	0	0	55,605	60.00
64.00	06400	INTRAVENOUS THERAPY		0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY		0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY		0	0	0	0	0	66.00
66.01	03951	CLINICAL NUTRITION		0	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY		0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY		0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY		0	0	0	0	0	69.00
69.01	06901	CARDIAC REHABILITATION		0	0	0	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY		0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS		0	0	0	0	0	74.00
76.00	03950	ENDOSCOPY		0	0	0	0	0	76.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION		0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY		0	0	0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC		0	0	0	0	0	90.00
91.00	09100	EMERGENCY		0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		0	0	0	0	55,605	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0046 Component CCN: 14-T046		Period: From 01/01/2023 To 12/31/2023		Worksheet D Part IV Date/Time Prepared: 5/21/2024 10:06 am	
				Title XVIII		Subprovider - IRF		PPS	
Cost Center Description				All Other Medical Education Cost	Total Cost (sum of col.s. 1, 2, 3, and 4)	Total Outpatient Cost (sum of col.s. 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	98,806,118	0.000000	50.00
51.00	05100	RECOVERY ROOM		0	0	0	14,188,587	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0	0	0	21,855,255	0.000000	52.00
53.00	05300	ANESTHESIOLOGY		0	0	0	32,315,437	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	23,913,952	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC		0	0	0	4,411,017	0.000000	55.00
56.00	05600	RADIOISOTOPE		0	0	0	11,377,558	0.000000	56.00
57.00	05700	CT SCAN		0	0	0	79,805,150	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)		0	0	0	13,770,222	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION		0	0	0	46,454,822	0.000000	59.00
60.00	06000	LABORATORY		0	55,605	55,605	85,135,298	0.000653	60.00
64.00	06400	INTRAVENOUS THERAPY		0	0	0	1,046,106	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY		0	0	0	14,331,789	0.000000	65.00
66.00	06600	PHYSICAL THERAPY		0	0	0	8,267,833	0.000000	66.00
66.01	03951	CLINICAL NUTRITION		0	0	0	23,661	0.000000	66.01
67.00	06700	OCCUPATIONAL THERAPY		0	0	0	3,714,448	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY		0	0	0	2,100,940	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY		0	0	0	26,377,877	0.000000	69.00
69.01	06901	CARDIAC REHABILITATION		0	0	0	777,975	0.000000	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY		0	0	0	224,900	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		0	0	0	14,582,309	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0	0	0	9,824,333	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	67,139,055	0.000000	73.00
74.00	07400	RENAL DIALYSIS		0	0	0	2,211,858	0.000000	74.00
76.00	03950	ENDOSCOPY		0	0	0	0	0.000000	76.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION		0	0	0	0	0.000000	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY		0	0	0	0	0.000000	78.00
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC		0	0	0	14,028,556	0.000000	90.00
91.00	09100	EMERGENCY		0	0	0	47,911,477	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0	0	0	1,632,754	0.000000	92.00
200.00		Total (lines 50 through 199)		0	55,605	55,605	646,229,287		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0046 Component CCN: 14-T046		Period: From 01/01/2023 To 12/31/2023		Worksheet D Part IV Date/Time Prepared: 5/21/2024 10:06 am	
				Title XVIII		Subprovider - IRF		PPS	
Cost Center Description				Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
				9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0.000000	2,247	0	0	0	50.00
51.00	05100	RECOVERY ROOM		0.000000	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY		0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0.000000	22,912	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC		0.000000	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE		0.000000	7,188	0	0	0	56.00
57.00	05700	CT SCAN		0.000000	37,052	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)		0.000000	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION		0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY		0.000653	256,381	167	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY		0.000000	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY		0.000000	195,018	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY		0.000000	696,601	0	0	0	66.00
66.01	03951	CLINICAL NUTRITION		0.000000	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY		0.000000	700,683	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY		0.000000	258,020	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY		0.000000	13,213	0	0	0	69.00
69.01	06901	CARDIAC REHABILITATION		0.000000	0	0	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY		0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		0.000000	82,485	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0.000000	3,402	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0.000000	195,496	0	0	0	73.00
74.00	07400	RENAL DIALYSIS		0.000000	24,092	0	0	0	74.00
76.00	03950	ENDOSCOPY		0.000000	0	0	0	0	76.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION		0.000000	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY		0.000000	0	0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC		0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY		0.000000	53,174	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)			2,547,964	167	0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-0046

Period:
From 01/01/2023
To 12/31/2023Worksheet D
Part I
Date/Time Prepared:
5/21/2024 10:06 am

Cost Center Description			Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Hospital Total Patient Days	PPS Per Diem (col. 3 / col. 4)	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	ADULTS & PEDIATRICS	2,594,051	0	2,594,051	26,220	98.93	30.00	
31.00	INTENSIVE CARE UNIT	667,354		667,354	2,551	261.60	31.00	
41.00	SUBPROVIDER - IRF	400,910	0	400,910	2,360	169.88	41.00	
43.00	NURSERY	84,644		84,644	2,093	40.44	43.00	
200.00	Total (lines 30 through 199)	3,746,959		3,746,959	33,224		200.00	
Cost Center Description			Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
			6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	ADULTS & PEDIATRICS	306	30,273				30.00	
31.00	INTENSIVE CARE UNIT	37	9,679				31.00	
41.00	SUBPROVIDER - IRF	22	3,737				41.00	
43.00	NURSERY	1,551	62,722				43.00	
200.00	Total (lines 30 through 199)	1,916	106,411				200.00	

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0046

Period:
From 01/01/2023
To 12/31/2023Worksheet D
Part II
Date/Time Prepared:
5/21/2024 10:06 am

Cost Center Description		Title XIX		Hospital		PPS	
		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	1,669,855	98,806,118	0.016900	0	0	50.00
51.00	05100 RECOVERY ROOM	29,811	14,188,587	0.002101	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	436,238	21,855,255	0.019960	0	0	52.00
53.00	05300 ANESTHESIOLOGY	88,565	32,315,437	0.002741	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	791,591	23,913,952	0.033102	0	0	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	155,287	4,411,017	0.035204	0	0	55.00
56.00	05600 RADIOISOTOPE	18,235	11,377,558	0.001603	0	0	56.00
57.00	05700 CT SCAN	229,304	79,805,150	0.002873	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	215,946	13,770,222	0.015682	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	329,349	46,454,822	0.007090	0	0	59.00
60.00	06000 LABORATORY	410,571	85,135,298	0.004823	0	0	60.00
64.00	06400 INTRAVENOUS THERAPY	48,809	1,046,106	0.046658	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	241,931	14,331,789	0.016881	0	0	65.00
66.00	06600 PHYSICAL THERAPY	139,336	8,267,833	0.016853	0	0	66.00
66.01	03951 CLINICAL NUTRITION	2,767	23,661	0.116943	0	0	66.01
67.00	06700 OCCUPATIONAL THERAPY	117,661	3,714,448	0.031677	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	27,966	2,100,940	0.013311	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	891,064	26,377,877	0.033781	0	0	69.00
69.01	06901 CARDIAC REHABILITATION	12,086	777,975	0.015535	0	0	69.01
70.00	07000 ELECTROENCEPHALOGRAPHY	41,415	224,900	0.184149	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	69,404	14,582,309	0.004759	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	30,408	9,824,333	0.003095	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	120,813	67,139,055	0.001799	0	0	73.00
74.00	07400 RENAL DIALYSIS	6,589	2,211,858	0.002979	0	0	74.00
76.00	03950 ENDOSCOPY	0	0	0.000000	0	0	76.00
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0	0	0.000000	0	0	77.00
78.00	07800 CAR T-CELL IMMUNOTHERAPY	0	0	0.000000	0	0	78.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	1,416,970	14,028,556	0.101006	0	0	90.00
91.00	09100 EMERGENCY	582,600	47,911,477	0.012160	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	100,121	1,632,754	0.061320	0	0	92.00
200.00	Total (lines 50 through 199)	8,224,692	646,229,287		0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-0046		Period: From 01/01/2023 To 12/31/2023		Worksheet D Part III Date/Time Prepared: 5/21/2024 10:06 am	
					Title XIX		Hospital		PPS	
Cost Center Description			Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost			
			1A	1.00	2A	2.00	3.00			
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00		
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00		
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00		
43.00	04300	NURSERY	0	0	0	0	0	43.00		
200.00		Total (lines 30 through 199)	0	0	0	0	0	200.00		
Cost Center Description			Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days			
			4.00	5.00	6.00	7.00	8.00			
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	0	0	26,220	0.00	306	30.00		
31.00	03100	INTENSIVE CARE UNIT		0	2,551	0.00	37	31.00		
41.00	04100	SUBPROVIDER - IRF	0	0	2,360	0.00	22	41.00		
43.00	04300	NURSERY		0	2,093	0.00	1,551	43.00		
200.00		Total (lines 30 through 199)		0	33,224		1,916	200.00		
Cost Center Description			Inpatient Program Pass-Through Cost (col. 7 x col. 8)							
			9.00							
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	0						30.00	
31.00	03100	INTENSIVE CARE UNIT	0						31.00	
41.00	04100	SUBPROVIDER - IRF	0						41.00	
43.00	04300	NURSERY	0						43.00	
200.00		Total (lines 30 through 199)	0						200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0046

Period:
From 01/01/2023
To 12/31/2023Worksheet D
Part IV
Date/Time Prepared:
5/21/2024 10:06 am

Cost Center Description			Title XIX			Hospital	PPS	
			Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	55,605	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
66.01	03951	CLINICAL NUTRITION	0	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	CARDIAC REHABILITATION	0	0	0	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	ENDOSCOPY	0	0	0	0	0	76.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	55,605	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0046		Period: From 01/01/2023 To 12/31/2023		Worksheet D Part IV Date/Time Prepared: 5/21/2024 10:06 am	
				Title XIX		Hospital		PPS	
Cost Center Description				All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
				4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0	0	0	98,806,118	0.000000	50.00
51.00	05100	RECOVERY ROOM		0	0	0	14,188,587	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0	0	0	21,855,255	0.000000	52.00
53.00	05300	ANESTHESIOLOGY		0	0	0	32,315,437	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	23,913,952	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC		0	0	0	4,411,017	0.000000	55.00
56.00	05600	RADIOISOTOPE		0	0	0	11,377,558	0.000000	56.00
57.00	05700	CT SCAN		0	0	0	79,805,150	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)		0	0	0	13,770,222	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION		0	0	0	46,454,822	0.000000	59.00
60.00	06000	LABORATORY		0	55,605	55,605	85,135,298	0.000653	60.00
64.00	06400	INTRAVENOUS THERAPY		0	0	0	1,046,106	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY		0	0	0	14,331,789	0.000000	65.00
66.00	06600	PHYSICAL THERAPY		0	0	0	8,267,833	0.000000	66.00
66.01	03951	CLINICAL NUTRITION		0	0	0	23,661	0.000000	66.01
67.00	06700	OCCUPATIONAL THERAPY		0	0	0	3,714,448	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY		0	0	0	2,100,940	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY		0	0	0	26,377,877	0.000000	69.00
69.01	06901	CARDIAC REHABILITATION		0	0	0	777,975	0.000000	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY		0	0	0	224,900	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		0	0	0	14,582,309	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0	0	0	9,824,333	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	67,139,055	0.000000	73.00
74.00	07400	RENAL DIALYSIS		0	0	0	2,211,858	0.000000	74.00
76.00	03950	ENDOSCOPY		0	0	0	0	0.000000	76.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION		0	0	0	0	0.000000	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY		0	0	0	0	0.000000	78.00
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC		0	0	0	14,028,556	0.000000	90.00
91.00	09100	EMERGENCY		0	0	0	47,911,477	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0	0	0	1,632,754	0.000000	92.00
200.00		Total (lines 50 through 199)		0	55,605	55,605	646,229,287		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0046

Period:
From 01/01/2023
To 12/31/2023Worksheet D
Part IV
Date/Time Prepared:
5/21/2024 10:06 am

				Title XIX		Hospital		PPS	
Cost Center Description			Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			9.00						10.00
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.000000	0	0	0	0	50.00	
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00	
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	0	0	0	0	54.00	
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	0	55.00	
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00	
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00	
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0	58.00	
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00	
60.00	06000	LABORATORY	0.000653	0	0	0	0	60.00	
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00	
65.00	06500	RESPIRATORY THERAPY	0.000000	0	0	0	0	65.00	
66.00	06600	PHYSICAL THERAPY	0.000000	0	0	0	0	66.00	
66.01	03951	CLINICAL NUTRITION	0.000000	0	0	0	0	66.01	
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00	
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00	
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00	
69.01	06901	CARDIAC REHABILITATION	0.000000	0	0	0	0	69.01	
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	0	0	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	0	0	0	0	73.00	
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00	
76.00	03950	ENDOSCOPY	0.000000	0	0	0	0	76.00	
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	0	0	77.00	
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000	0	0	0	0	78.00	
	OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00	
91.00	09100	EMERGENCY	0.000000	0	0	0	0	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00	
200.00		Total (lines 50 through 199)		0	0	0	0	200.00	

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS				Provider CCN: 14-0046	Period: From 01/01/2023 To 12/31/2023	Worksheet D Part II Date/Time Prepared: 5/21/2024 10:06 am
				Component CCN: 14-T046		
				Title XIX	Subprovider - IRF	PPS
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)
		1.00	2.00	3.00	4.00	5.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	1,669,855	98,806,118	0.016900	0	0 50.00
51.00	05100 RECOVERY ROOM	29,811	14,188,587	0.002101	0	0 51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	436,238	21,855,255	0.019960	0	0 52.00
53.00	05300 ANESTHESIOLOGY	88,565	32,315,437	0.002741	0	0 53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	791,591	23,913,952	0.033102	0	0 54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	155,287	4,411,017	0.035204	0	0 55.00
56.00	05600 RADIOISOTOPE	18,235	11,377,558	0.001603	0	0 56.00
57.00	05700 CT SCAN	229,304	79,805,150	0.002873	0	0 57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	215,946	13,770,222	0.015682	0	0 58.00
59.00	05900 CARDIAC CATHETERIZATION	329,349	46,454,822	0.007090	0	0 59.00
60.00	06000 LABORATORY	410,571	85,135,298	0.004823	0	0 60.00
64.00	06400 INTRAVENOUS THERAPY	48,809	1,046,106	0.046658	0	0 64.00
65.00	06500 RESPIRATORY THERAPY	241,931	14,331,789	0.016881	0	0 65.00
66.00	06600 PHYSICAL THERAPY	139,336	8,267,833	0.016853	0	0 66.00
66.01	03951 CLINICAL NUTRITION	2,767	23,661	0.116943	0	0 66.01
67.00	06700 OCCUPATIONAL THERAPY	117,661	3,714,448	0.031677	0	0 67.00
68.00	06800 SPEECH PATHOLOGY	27,966	2,100,940	0.013311	0	0 68.00
69.00	06900 ELECTROCARDIOLOGY	891,064	26,377,877	0.033781	0	0 69.00
69.01	06901 CARDIAC REHABILITATION	12,086	777,975	0.015535	0	0 69.01
70.00	07000 ELECTROENCEPHALOGRAPHY	41,415	224,900	0.184149	0	0 70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	69,404	14,582,309	0.004759	0	0 71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	30,408	9,824,333	0.003095	0	0 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	120,813	67,139,055	0.001799	0	0 73.00
74.00	07400 RENAL DIALYSIS	6,589	2,211,858	0.002979	0	0 74.00
76.00	03950 ENDOSCOPY	0	0	0.000000	0	0 76.00
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0	0	0.000000	0	0 77.00
78.00	07800 CAR T-CELL IMMUNOTHERAPY	0	0	0.000000	0	0 78.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	1,416,970	14,028,556	0.101006	0	0 90.00
91.00	09100 EMERGENCY	582,600	47,911,477	0.012160	0	0 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	1,632,754	0.000000	0	0 92.00
200.00	Total (lines 50 through 199)	8,124,571	646,229,287		0	0 200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0046 Component CCN: 14-T046		Period: From 01/01/2023 To 12/31/2023		Worksheet D Part IV Date/Time Prepared: 5/21/2024 10:06 am	
				Title XIX		Subprovider - IRF		PPS	
Cost Center Description				Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
				1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM		0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY		0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC		0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE		0	0	0	0	0	56.00
57.00	05700	CT SCAN		0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)		0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION		0	0	0	0	0	59.00
60.00	06000	LABORATORY		0	0	0	0	55,605	60.00
64.00	06400	INTRAVENOUS THERAPY		0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY		0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY		0	0	0	0	0	66.00
66.01	03951	CLINICAL NUTRITION		0	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY		0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY		0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY		0	0	0	0	0	69.00
69.01	06901	CARDIAC REHABILITATION		0	0	0	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY		0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS		0	0	0	0	0	74.00
76.00	03950	ENDOSCOPY		0	0	0	0	0	76.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION		0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY		0	0	0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC		0	0	0	0	0	90.00
91.00	09100	EMERGENCY		0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		0	0	0	0	55,605	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0046 Component CCN: 14-T046		Period: From 01/01/2023 To 12/31/2023		Worksheet D Part IV Date/Time Prepared: 5/21/2024 10:06 am	
				Title XIX		Subprovider - IRF		PPS	
Cost Center Description				All Other Medical Education Cost	Total Cost (sum of col.s. 1, 2, 3, and 4)	Total Outpatient Cost (sum of col.s. 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	98,806,118	0.000000	50.00
51.00	05100	RECOVERY ROOM		0	0	0	14,188,587	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0	0	0	21,855,255	0.000000	52.00
53.00	05300	ANESTHESIOLOGY		0	0	0	32,315,437	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	23,913,952	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC		0	0	0	4,411,017	0.000000	55.00
56.00	05600	RADIOISOTOPE		0	0	0	11,377,558	0.000000	56.00
57.00	05700	CT SCAN		0	0	0	79,805,150	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)		0	0	0	13,770,222	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION		0	0	0	46,454,822	0.000000	59.00
60.00	06000	LABORATORY		0	55,605	55,605	85,135,298	0.000653	60.00
64.00	06400	INTRAVENOUS THERAPY		0	0	0	1,046,106	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY		0	0	0	14,331,789	0.000000	65.00
66.00	06600	PHYSICAL THERAPY		0	0	0	8,267,833	0.000000	66.00
66.01	03951	CLINICAL NUTRITION		0	0	0	23,661	0.000000	66.01
67.00	06700	OCCUPATIONAL THERAPY		0	0	0	3,714,448	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY		0	0	0	2,100,940	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY		0	0	0	26,377,877	0.000000	69.00
69.01	06901	CARDIAC REHABILITATION		0	0	0	777,975	0.000000	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY		0	0	0	224,900	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		0	0	0	14,582,309	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0	0	0	9,824,333	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	67,139,055	0.000000	73.00
74.00	07400	RENAL DIALYSIS		0	0	0	2,211,858	0.000000	74.00
76.00	03950	ENDOSCOPY		0	0	0	0	0.000000	76.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION		0	0	0	0	0.000000	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY		0	0	0	0	0.000000	78.00
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC		0	0	0	14,028,556	0.000000	90.00
91.00	09100	EMERGENCY		0	0	0	47,911,477	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0	0	0	1,632,754	0.000000	92.00
200.00		Total (lines 50 through 199)		0	55,605	55,605	646,229,287		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0046 Component CCN: 14-T046		Period: From 01/01/2023 To 12/31/2023		Worksheet D Part IV Date/Time Prepared: 5/21/2024 10:06 am	
				Title XIX		Subprovider - IRF		PPS	
Cost Center Description				Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
				9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0.000000	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM		0.000000	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY		0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0.000000	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC		0.000000	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE		0.000000	0	0	0	0	56.00
57.00	05700	CT SCAN		0.000000	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)		0.000000	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION		0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY		0.000653	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY		0.000000	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY		0.000000	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY		0.000000	0	0	0	0	66.00
66.01	03951	CLINICAL NUTRITION		0.000000	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY		0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY		0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY		0.000000	0	0	0	0	69.00
69.01	06901	CARDIAC REHABILITATION		0.000000	0	0	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY		0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		0.000000	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0.000000	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS		0.000000	0	0	0	0	74.00
76.00	03950	ENDOSCOPY		0.000000	0	0	0	0	76.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION		0.000000	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY		0.000000	0	0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC		0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY		0.000000	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)			0	0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0046	Period: From 01/01/2023 To 12/31/2023	Worksheet D-1 Date/Time Prepared: 5/21/2024 10:06 am
		Title XVIII	Hospital	PPS
Cost Center Description				
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		26,220	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		26,220	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)		25,208	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		11,378	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		40,135,402	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		40,135,402	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)		40,135,402	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)		1,530.72	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		17,416,532	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)		17,416,532	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0046

Period:
From 01/01/2023
To 12/31/2023

Worksheet D-1

Date/Time Prepared:
5/21/2024 10:06 am

		Title XVIII		Hospital		PPS	
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	6,785,914	2,551	2,660.10	1,069	2,843,647	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)					21,702,945	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)					41,963,124	49.00
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					1,405,276	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					1,356,625	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					2,761,901	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					39,201,223	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
55.01	Permanent adjustment amount per discharge					0.00	55.01
55.02	Adjustment amount per discharge (contractor use only)					0.00	55.02
56.00	Target amount (line 54 x sum of lines 55, 55.01, and 55.02)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)					0.00	59.00
60.00	Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)					0.00	60.00
61.00	Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					1,012	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,530.72	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					1,549.089	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0046

Period:
From 01/01/2023
To 12/31/2023

Worksheet D-1

Date/Time Prepared:
5/21/2024 10:06 am

		Title XVIII		Hospital	PPS	
Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00 Capital-related cost	2,594,051	40,135,402	0.064632	1,549,089	100,121	90.00
91.00 Nursing Program cost	0	40,135,402	0.000000	1,549,089	0	91.00
92.00 Allied health cost	0	40,135,402	0.000000	1,549,089	0	92.00
93.00 All other Medical Education	0	40,135,402	0.000000	1,549,089	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0046 Component CCN: 14-T046	Period: From 01/01/2023 To 12/31/2023	Worksheet D-1 Date/Time Prepared: 5/21/2024 10:06 am
		Title XVIII	Subprovider - IRF	PPS
Cost Center Description			1.00	
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		2,360	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		2,360	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		2,360	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		1,236	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		5,207,513	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		5,207,513	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)		5,207,513	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)		2,206.57	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		2,727,321	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		2,727,321	41.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 14-0046	Period: From 01/01/2023 To 12/31/2023	Worksheet D-1	
				Component CCN: 14-T046		Date/Time Prepared: 5/21/2024 10:06 am	
				Title XVIII		Subprovider - IRF	PPS
	Cost Center Description	Total	Total	Average Per	Program Days	Program Cost	
		Inpatient Cost	Inpatient Days	Diem (col. 1 ÷ col. 2)		(col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description							
							1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					777,377	48.00
48.01	Program inpatient cellular therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1)					0	48.01
49.00	Total Program inpatient costs (sum of lines 41 through 48.01)(see instructions)					3,504,698	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)					209,972	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					44,902	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					254,874	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					3,249,824	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
55.01	Permanent adjustment amount per discharge					0.00	55.01
55.02	Adjustment amount per discharge (contractor use only)					0.00	55.02
56.00	Target amount (line 54 x sum of lines 55, 55.01, and 55.02)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)					0.00	59.00
60.00	Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)					0.00	60.00
61.00	Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00	88.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 14-0046 Component CCN: 14-T046		Period: From 01/01/2023 To 12/31/2023		Worksheet D-1 Date/Time Prepared: 5/21/2024 10:06 am	
				Title XVIII		Subprovider - IRF		PPS	
Cost Center Description								1.00	
89.00	Observation bed cost (line 87 x line 88) (see instructions)						0	89.00	
Cost Center Description			Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
			1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH COST									
90.00	Capital-related cost			400,910	5,207,513	0.076987	0	90.00	
91.00	Nursing Program cost			0	5,207,513	0.000000	0	91.00	
92.00	Allied health cost			0	5,207,513	0.000000	0	92.00	
93.00	All other Medical Education			0	5,207,513	0.000000	0	93.00	

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0046	Period: From 01/01/2023 To 12/31/2023	Worksheet D-1 Date/Time Prepared: 5/21/2024 10:06 am
		Title XIX	Hospital	PPS
Cost Center Description				
PART I - ALL PROVIDER COMPONENTS				1.00
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		26,220	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		26,220	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)		25,208	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		306	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		2,093	15.00
16.00	Nursery days (title V or XIX only)		1,551	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		40,135,402	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		40,135,402	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)		40,135,402	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)		1,530.72	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		468,400	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)		468,400	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0046

Period:
From 01/01/2023
To 12/31/2023

Worksheet D-1

Date/Time Prepared:

5/21/2024 10:06 am

		Title XIX		Hospital	PPS	
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
		1.00	2.00	3.00	4.00	5.00
42.00	NURSERY (title V & XIX only)	2,308,707	2,093	1,103.06	1,551	1,710,846
Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	6,785,914	2,551	2,660.10	37	98,424
44.00	CORONARY CARE UNIT					
45.00	BURN INTENSIVE CARE UNIT					
46.00	SURGICAL INTENSIVE CARE UNIT					
47.00	OTHER SPECIAL CARE (SPECIFY)					
Cost Center Description						
						1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					0
48.01	Program inpatient cellular therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1)					0
49.00	Total Program inpatient costs (sum of lines 41 through 48.01)(see instructions)					2,277,670
PASS THROUGH COST ADJUSTMENTS						
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					102,674
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0
52.00	Total Program excludable cost (sum of lines 50 and 51)					102,674
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					2,174,996
TARGET AMOUNT AND LIMIT COMPUTATION						
54.00	Program discharges					0
55.00	Target amount per discharge					0.00
55.01	Permanent adjustment amount per discharge					0.00
55.02	Adjustment amount per discharge (contractor use only)					0.00
56.00	Target amount (line 54 x sum of lines 55, 55.01, and 55.02)					0
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0
58.00	Bonus payment (see instructions)					0
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
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
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
62.00	Relief payment (see instructions)					0
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0
PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions					0
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
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
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0
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)					1,012
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,530.72
89.00	Observation bed cost (line 87 x line 88) (see instructions)					1,549,089

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0046

Period:
From 01/01/2023
To 12/31/2023

Worksheet D-1

Date/Time Prepared:
5/21/2024 10:06 am

Cost Center Description		Title XIX		Hospital	PPS	
		Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	2,594,051	40,135,402	0.064632	1,549,089	100,121
91.00	Nursing Program cost	0	40,135,402	0.000000	1,549,089	0
92.00	Allied health cost	0	40,135,402	0.000000	1,549,089	0
93.00	All other Medical Education	0	40,135,402	0.000000	1,549,089	0

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0046 Component CCN: 14-T046	Period: From 01/01/2023 To 12/31/2023	Worksheet D-1 Date/Time Prepared: 5/21/2024 10:06 am
		Title XIX	Subprovider - IRF	PPS
Cost Center Description			1.00	
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		2,360	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		2,360	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		2,360	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		22	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		2,093	15.00
16.00	Nursery days (title V or XIX only)		1,551	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		5,207,513	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		5,207,513	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)		5,207,513	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)		2,206.57	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		48,545	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)		48,545	41.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 14-0046	Period: From 01/01/2023 To 12/31/2023	Worksheet D-1	
				Component CCN: 14-T046		Date/Time Prepared: 5/21/2024 10:06 am	
				Title XIX		Subprovider - IRF	PPS
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)		0	0	0.00	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT		0	0	0.00	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					0	48.00
48.01	Program inpatient cellular therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1)					0	48.01
49.00	Total Program inpatient costs (sum of lines 41 through 48.01)(see instructions)					48,545	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)					3,737	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)					3,737	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					44,808	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
55.01	Permanent adjustment amount per discharge					0.00	55.01
55.02	Adjustment amount per discharge (contractor use only)					0.00	55.02
56.00	Target amount (line 54 x sum of lines 55, 55.01, and 55.02)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)					0.00	59.00
60.00	Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)					0.00	60.00
61.00	Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00	88.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 14-0046 Component CCN: 14-T046		Period: From 01/01/2023 To 12/31/2023		Worksheet D-1 Date/Time Prepared: 5/21/2024 10:06 am	
				Title XIX		Subprovider - IRF		PPS	
Cost Center Description									
								1.00	
89.00	Observation bed cost (line 87 x line 88) (see instructions)							0	89.00
Cost Center Description			Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
			1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH COST									
90.00	Capital-related cost			400,910	5,207,513	0.076987	0	90.00	
91.00	Nursing Program cost			0	5,207,513	0.000000	0	91.00	
92.00	Allied health cost			0	5,207,513	0.000000	0	92.00	
93.00	All other Medical Education			0	5,207,513	0.000000	0	93.00	

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-0046	Period: From 01/01/2023 To 12/31/2023	Worksheet D-3 Date/Time Prepared: 5/21/2024 10:06 am	
Cost Center Description			Title XVIII	Hospital	PPS	
			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		20,234,764		30.00
31.00	03100	INTENSIVE CARE UNIT		2,816,815		31.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
43.00	04300	NURSERY				43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.120799	22,455,554	2,712,608	50.00
51.00	05100	RECOVERY ROOM	0.133161	2,146,321	285,806	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.327798	15,642	5,127	52.00
53.00	05300	ANESTHESIOLOGY	0.029592	3,462,665	102,467	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.226835	3,242,553	735,525	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.676343	420	284	55.00
56.00	05600	RADIOISOTOPE	0.090727	850,094	77,126	56.00
57.00	05700	CT SCAN	0.025042	11,617,631	290,929	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.069751	1,406,404	98,098	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.070302	0	0	59.00
60.00	06000	LABORATORY	0.089279	15,509,252	1,384,651	60.00
64.00	06400	INTRAVENOUS THERAPY	0.535433	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.281805	5,003,181	1,409,921	65.00
66.00	06600	PHYSICAL THERAPY	0.302353	2,137,262	646,208	66.00
66.01	03951	CLINICAL NUTRITION	12.357001	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0.353367	1,111,018	392,597	67.00
68.00	06800	SPEECH PATHOLOGY	0.323564	409,523	132,507	68.00
69.00	06900	ELECTROCARDIOLOGY	0.267353	11,712,856	3,131,467	69.00
69.01	06901	CARDIAC REHABILITATION	0.398136	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.809435	91,000	73,659	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.898078	4,519,267	4,058,654	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.572170	2,599,919	1,487,596	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.249100	11,118,638	2,769,653	73.00
74.00	07400	RENAL DIALYSIS	0.565350	1,233,487	697,352	74.00
76.00	03950	ENDOSCOPY	0.000000	0	0	76.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000	0	0	78.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.785468	1,104	867	90.00
91.00	09100	EMERGENCY	0.167441	6,464,687	1,082,454	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.948758	134,269	127,389	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		107,242,747	21,702,945	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)		107,242,747		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0046	Period: From 01/01/2023 To 12/31/2023	Worksheet D-3	
		Component CCN: 14-T046		Date/Time Prepared: 5/21/2024 10:06 am	
		Title XVIII	Subprovider - IRF	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00
31.00	03100 INTENSIVE CARE UNIT				31.00
41.00	04100 SUBPROVIDER - IRF		1,862,652		41.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.120799	2,247	271	50.00
51.00	05100 RECOVERY ROOM	0.133161	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.327798	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.029592	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.226835	22,912	5,197	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.676343	0	0	55.00
56.00	05600 RADIOISOTOPE	0.090727	7,188	652	56.00
57.00	05700 CT SCAN	0.025042	37,052	928	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.069751	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.070302	0	0	59.00
60.00	06000 LABORATORY	0.089279	256,381	22,889	60.00
64.00	06400 INTRAVENOUS THERAPY	0.535433	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.281805	195,018	54,957	65.00
66.00	06600 PHYSICAL THERAPY	0.302353	696,601	210,619	66.00
66.01	03951 CLINICAL NUTRITION	12.357001	0	0	66.01
67.00	06700 OCCUPATIONAL THERAPY	0.353367	700,683	247,598	67.00
68.00	06800 SPEECH PATHOLOGY	0.323564	258,020	83,486	68.00
69.00	06900 ELECTROCARDIOLOGY	0.267353	13,213	3,533	69.00
69.01	06901 CARDIAC REHABILITATION	0.398136	0	0	69.01
70.00	07000 ELECTROENCEPHALOGRAPHY	0.809435	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.898078	82,485	74,078	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.572170	3,402	1,947	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.249100	195,496	48,698	73.00
74.00	07400 RENAL DIALYSIS	0.565350	24,092	13,620	74.00
76.00	03950 ENDOSCOPY	0.000000	0	0	76.00
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	77.00
78.00	07800 CAR T-CELL IMMUNOTHERAPY	0.000000	0	0	78.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.785468	0	0	90.00
91.00	09100 EMERGENCY	0.167441	53,174	8,904	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.948758	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		2,547,964	777,377	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net charges (line 200 minus line 201)		2,547,964		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0046	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part A Date/Time Prepared: 5/21/2024 10:06 am
		Title XVIII	Hospital	PPS
				1.00
PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS				
1.00	DRG Amounts Other than Outlier Payments			0 1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)		19,799,316	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		6,724,949	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)		0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)		0	1.04
2.00	Outlier payments for discharges. (see instructions)			2.00
2.01	Outlier reconciliation amount		0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)		0	2.02
2.03	Outlier payments for discharges occurring prior to October 1 (see instructions)		281,916	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)		58,564	2.04
3.00	Managed Care Simulated Payments		0	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		108.23	4.00
Indirect Medical Education Adjustment				
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996. (see instructions)		0.00	5.00
5.01	FTE cap adjustment for qualifying hospitals under §131 of the CAA 2021 (see instructions)		0.00	5.01
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00	6.00
6.26	Rural track program FTE cap limitation adjustment after the cap-building window closed under §127 of the CAA 2021 (see instructions)		0.00	6.26
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00	7.01
7.02	Adjustment (increase or decrease) to the hospital's rural track program FTE limitation(s) for rural track programs with a rural track for Medicare GME affiliated programs in accordance with 413.75(b) and 87 FR 49075 (August 10, 2022) (see instructions)		0.00	7.02
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).		0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)		0.00	8.02
8.21	The amount of increase if the hospital was awarded FTE cap slots under §126 of the CAA 2021 (see instructions)		0.00	8.21
9.00	Sum of lines 5 and 5.01, plus line 6, plus lines 6.26 through 6.49, minus lines 7 and 7.01, plus or minus line 7.02, plus/minus line 8, plus lines 8.01 through 8.27 (see instructions)		0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.		0.00	11.00
12.00	Current year allowable FTE (see instructions)		0.00	12.00
13.00	Total allowable FTE count for the prior year.		0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.		0.00	15.00
16.00	Adjustment for residents in initial years of the program (see instructions)		0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure		0.00	17.00
18.00	Adjusted rolling average FTE count		0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.000000	21.00
22.00	IME payment adjustment (see instructions)		0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)		0	22.01
Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA				
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).		0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)		0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)		0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)		0	28.01
29.00	Total IME payment (sum of lines 22 and 28)		0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		0	29.01
Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		5.10	30.00
31.00	Percentage of Medicaid patient days (see instructions)		22.81	31.00
32.00	Sum of lines 30 and 31		27.91	32.00
33.00	Allowable disproportionate share percentage (see instructions)		12.24	33.00
34.00	Disproportionate share adjustment (see instructions)		811,643	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0046	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part A Date/Time Prepared: 5/21/2024 10:06 am
		Title XVIII	Hospital	PPS
			Prior to 10/1	On/After 10/1
			1.00	2.00
Uncompensated Care Payment Adjustment				
35.00	Total uncompensated care amount (see instructions)		6,874,403,459	5,938,006,757
35.01	Factor 3 (see instructions)		0.000152934	0.000151862
35.02	Hospital UCP, including supplemental UCP (see instructions)		1,051,327	901,757
35.03	Pro rata share of the hospital UCP, including supplemental UCP (see instructions)		786,335	226,671
36.00	Total UCP adjustment (sum of columns 1 and 2 on line 35.03)		1,013,006	
Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)				
40.00	Total Medicare discharges (see instructions)		0	
41.00	Total ESRD Medicare discharges (see instructions)		0	
41.01	Total ESRD Medicare covered and paid discharges (see instructions)		0	
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)		0.00	
43.00	Total Medicare ESRD inpatient days (see instructions)		0	
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)		0.000000	
45.00	Average weekly cost for dialysis treatments (see instructions)		0.00	
46.00	Total additional payment (line 45 times line 44 times line 41.01)		0	
47.00	Subtotal (see instructions)		28,689,394	
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)		0	
			Amount	
			1.00	
49.00	Total payment for inpatient operating costs (see instructions)		28,689,394	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		2,057,927	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)		0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).		0	52.00
53.00	Nursing and Allied Health Managed Care payment		0	53.00
54.00	Special add-on payments for new technologies		30,601	54.00
54.01	Islet isolation add-on payment		0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)		0	55.00
55.01	Cellular therapy acquisition cost (see instructions)		0	55.01
56.00	Cost of physicians' services in a teaching hospital (see instructions)		0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).		0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		10,128	58.00
59.00	Total (sum of amounts on lines 49 through 58)		30,788,050	59.00
60.00	Primary payer payments		2,883	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		30,785,167	61.00
62.00	Deductibles billed to program beneficiaries		3,064,456	62.00
63.00	Coinurance billed to program beneficiaries		118,734	63.00
64.00	Allowable bad debts (see instructions)		783,440	64.00
65.00	Adjusted reimbursable bad debts (see instructions)		509,236	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		707,280	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		28,111,213	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)		0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)		0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	70.00
70.50	Rural Community Hospital Demonstration Project (\$410A Demonstration) adjustment (see instructions)		0	70.50
70.75	N95 respirator payment adjustment amount (see instructions)		0	70.75
70.87	Demonstration payment adjustment amount before sequestration		0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)		0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		0	70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)		0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)		0	70.91
70.92	Bundled Model 1 discount amount (see instructions)		0	70.92
70.93	HVBP payment adjustment amount (see instructions)		-16,425	70.93
70.94	HRR adjustment amount (see instructions)		-47,368	70.94
70.95	Recovery of accelerated depreciation		0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0046	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part A Date/Time Prepared: 5/21/2024 10:06 am
		Title XVIII	Hospital	PPS
		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0	70.97
70.98	Low Volume Payment-3	0	0	70.98
70.99	HAC adjustment amount (see instructions)		0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		28,047,420	71.00
71.01	Sequestration adjustment (see instructions)		560,948	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
71.03	Sequestration adjustment-PARHM pass-throughs			71.03
72.00	Interim payments		27,501,379	72.00
72.01	Interim payments-PARHM			72.01
73.00	Tentative settlement (for contractor use only)		0	73.00
73.01	Tentative settlement-PARHM (for contractor use only)			73.01
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)		-14,907	74.00
74.01	Balance due provider/program-PARHM (see instructions)			74.01
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		935,474	75.00
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)				
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00
		Prior to 10/1	On/After 10/1	
		1.00	2.00	
HSP Bonus Payment Amount				
100.00	HSP bonus amount (see instructions)		0	100.00
HVBP Adjustment for HSP Bonus Payment				
101.00	HVBP adjustment factor (see instructions)	0.0000000000	0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)	0	0	102.00
HRR Adjustment for HSP Bonus Payment				
103.00	HRR adjustment factor (see instructions)	0.0000	0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)	0	0	104.00
Rural Community Hospital Demonstration Project (\$410A Demonstration) Adjustment				
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
Cost Reimbursement				
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)			201.00
202.00	Medicare discharges (see instructions)			202.00
203.00	Case-mix adjustment factor (see instructions)			203.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)				
204.00	Medicare target amount			204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)			205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)			206.00
Adjustment to Medicare Part A Inpatient Reimbursement				
207.00	Program reimbursement under the \$410A Demonstration (see instructions)			207.00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)			208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
211.00	Total adjustment to Medicare IPPS payments (see instructions)			211.00
Comparison of PPS versus Cost Reimbursement				
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)			212.00
213.00	Low-volume adjustment (see instructions)			213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)			218.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0046

Period:
From 01/01/2023
To 12/31/2023Worksheet E
Part A Exhibit 4
Date/Time Prepared:
5/21/2024 10:06 am

				Title XVIII		Hospital	PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	19,799,316	0	19,799,316		19,799,316	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	6,724,949	0		6,724,949	6,724,949	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00						2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0	2.01
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	281,916	0	281,916		281,916	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	58,564	0		58,564	58,564	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	0	4.00
Indirect Medical Education Adjustment								
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0	6.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA								
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0	9.01
Disproportionate Share Adjustment								
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1224	0.1224	0.1224	0.1224		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	811,643	0	605,859	205,784	811,643	11.00
11.01	Uncompensated care payments	36.00	1,013,006	0	786,335	226,671	1,013,006	11.01
Additional payment for high percentage of ESRD beneficiary discharges								
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	28,689,394	0	21,473,426	7,215,968	28,689,394	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	28,689,394	0	21,473,426	7,215,968	28,689,394	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	2,057,927	0	1,530,140	527,787	2,057,927	16.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0046

Period:
From 01/01/2023
To 12/31/2023Worksheet E
Part A Exhibit 4
Date/Time Prepared:
5/21/2024 10:06 am

				Title XVIII		Hospital	PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
17.00	Special add-on payments for new technologies	54.00	30,601	0	30,601	0	30,601	17.00
17.01	Net organ acquisition cost							17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00
19.00	SUBTOTAL			0	23,034,167	7,743,755	30,777,922	19.00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	2,009,385	0	1,488,807	520,578	2,009,385	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	48,542	0	41,333	7,209	48,542	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	2,057,927	0	1,530,140	527,787	2,057,927	26.00
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.000000	0.000000		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			0		0	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				0	0	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 14-0046

Period:
From 01/01/2023
To 12/31/2023Worksheet E
Part A Exhibit 5
Date/Time Prepared:
5/21/2024 10:06 am

		Title XVIII		Hospital		PPS	
		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (col s. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	19,799,316	19,799,316		19,799,316	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	6,724,949		6,724,949	6,724,949	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00					2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	281,916	281,916		281,916	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	58,564		58,564	58,564	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	4.00
Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	6.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	9.01
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1224	0.1224	0.1224		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	811,643	605,859	205,784	811,643	11.00
11.01	Uncompensated care payments	36.00	1,013,006	786,335	226,671	1,013,006	11.01
Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	28,689,394	21,473,426	7,215,968	28,689,394	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	28,689,394	21,473,426	7,215,968	28,689,394	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	2,057,927	1,530,140	527,787	2,057,927	16.00
17.00	Special add-on payments for new technologies	54.00	30,601	30,601	0	30,601	17.00
17.01	Net organ acquisition cost						17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			23,034,167	7,743,755	30,777,922	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 14-0046

Period:
From 01/01/2023
To 12/31/2023Worksheet E
Part A Exhibit 5
Date/Time Prepared:
5/21/2024 10:06 am

		Title XVIII		Hospital		PPS	
		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	2,009,385	1,488,807	520,578	2,009,385	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	48,542	41,333	7,209	48,542	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	2,057,927	1,530,140	527,787	2,057,927	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
27.00							27.00
28.00	Low volume adjustment prior to October 1	70.96	0	0		0	28.00
29.00	Low volume adjustment on or after October 1	70.97	0		0	0	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	-16,425	0	-16,425	-16,425	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0	0	0	0	30.01
31.00	HRR adjustment (see instructions)	70.94	-47,368	-21,813	-25,555	-47,368	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0	0	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		0	0	0	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		Y				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0046	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part B Date/Time Prepared: 5/21/2024 10:06 am
		Title XVIII	Hospital	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		7,395	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		18,867,235	2.00
3.00	OPPS or REH payments		18,049,571	3.00
4.00	Outlier payment (see instructions)		46,404	4.00
4.01	Outlier reconciliation amount (see instructions)		0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs including REH direct graduate medical education costs from Wkst. D, Pt. IV, col. 13, line 200		4,937	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		7,395	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		29,686	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)		29,686	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		29,686	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		22,291	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (see instructions)		7,395	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)		18,100,912	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		3,251,034	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)		14,857,273	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		0	28.00
28.50	REH facility payment amount (see instructions)			28.50
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27, 28, 28.50 and 29)		14,857,273	30.00
31.00	Primary payer payments		3,140	31.00
32.00	Subtotal (line 30 minus line 31)		14,854,133	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)		474,185	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		308,220	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		403,582	36.00
37.00	Subtotal (see instructions)		15,162,353	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	39.50
39.75	N95 respirator payment adjustment amount (see instructions)		0	39.75
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		15,162,353	40.00
40.01	Sequestration adjustment (see instructions)		303,247	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		15,031,838	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)		-172,732	43.00
43.01	Balance due provider/program-PARHM (see instructions)			43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0046	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part B Date/Time Prepared: 5/21/2024 10:06 am	
		Title XVIII	Hospital	PPS	
				1.00	
94.00	Total (sum of lines 91 and 93)			0	94.00
				1.00	
200.00	MEDICARE PART B ANCILLARY COSTS Part B Combined Billed Days			0	200.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-0046

Period:
From 01/01/2023
To 12/31/2023Worksheet E-1
Part I
Date/Time Prepared:
5/21/2024 10:06 am

		Title XVIII		Hospital		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		27,501,379		15,077,401	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00	
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01	
3.02			0		0	3.02	
3.03			0		0	3.03	
3.04			0		0	3.04	
3.05			0		0	3.05	
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM		0	08/01/2023	45,563	3.50	
3.51			0		0	3.51	
3.52			0		0	3.52	
3.53			0		0	3.53	
3.54			0		0	3.54	
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		-45,563	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)		27,501,379		15,031,838	4.00	
TO BE COMPLETED BY CONTRACTOR							
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00	
Program to Provider							
5.01	TENTATIVE TO PROVIDER		0		0	5.01	
5.02			0		0	5.02	
5.03			0		0	5.03	
Provider to Program							
5.50	TENTATIVE TO PROGRAM		0		0	5.50	
5.51			0		0	5.51	
5.52			0		0	5.52	
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99	
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00	
6.01	SETTLEMENT TO PROVIDER		0		0	6.01	
6.02	SETTLEMENT TO PROGRAM		14,907		172,732	6.02	
7.00	Total Medicare program liability (see instructions)		27,486,472		14,859,106	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: 14-0046
 Component CCN: 14-T046

 Period:
 From 01/01/2023
 To 12/31/2023

 Worksheet E-1
 Part I
 Date/Time Prepared:
 5/21/2024 10:06 am

		Title XVIII		Subprovider - IRF		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider					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		2,303,009			0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						3.00
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER		0			0	3.01
3.02			0			0	3.02
3.03			0			0	3.03
3.04			0			0	3.04
3.05			0			0	3.05
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM		0			0	3.50
3.51			0			0	3.51
3.52			0			0	3.52
3.53			0			0	3.53
3.54			0			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0			0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		2,303,009			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		976,624			0	6.01
6.02	SETTLEMENT TO PROGRAM		0			0	6.02
7.00	Total Medicare program liability (see instructions)		3,279,633			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: 14-0046

Period:
From 01/01/2023
To 12/31/2023Worksheet E-1
Part II
Date/Time Prepared:
5/21/2024 10:06 am

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

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0046 Component CCN: 14-T046	Period: From 01/01/2023 To 12/31/2023	Worksheet E-3 Part III Date/Time Prepared: 5/21/2024 10:06 am
		Title XVIII	Subprovider - IRF	PPS
				1.00
PART III - MEDICARE PART A SERVICES - IRF PPS				
1.00	Net Federal PPS Payment (see instructions)			2,209,693 1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)			2.5000 2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)			1,106,172 3.00
4.00	Outlier Payments			48,248 4.00
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)			0.00 5.00
5.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)			0.00 5.01
6.00	New Teaching program adjustment. (see instructions)			0.00 6.00
7.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)			0.00 7.00
8.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)			0.00 8.00
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)			0.00 9.00
10.00	Average Daily Census (see instructions)			6.465753 10.00
11.00	Teaching Adjustment Factor (see instructions)			0.000000 11.00
12.00	Teaching Adjustment (see instructions)			0 12.00
13.00	Total PPS Payment (see instructions)			3,364,113 13.00
14.00	Nursing and Allied Health Managed Care payments (see instruction)			0 14.00
15.00	Organ acquisition (DO NOT USE THIS LINE)			0 15.00
16.00	Cost of physicians' services in a teaching hospital (see instructions)			0 16.00
17.00	Subtotal (see instructions)			3,364,113 17.00
18.00	Primary payer payments			0 18.00
19.00	Subtotal (line 17 less line 18).			3,364,113 19.00
20.00	Deductibles			12,756 20.00
21.00	Subtotal (line 19 minus line 20)			3,351,357 21.00
22.00	Coinurance			6,000 22.00
23.00	Subtotal (line 21 minus line 22)			3,345,357 23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			1,600 24.00
25.00	Adjusted reimbursable bad debts (see instructions)			1,040 25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			1,600 26.00
27.00	Subtotal (sum of lines 23 and 25)			3,346,397 27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 49)			0 28.00
29.00	Other pass through costs (see instructions)			167 29.00
30.00	Outlier payments reconciliation			0 30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 31.00
31.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 31.50
31.98	Recovery of accelerated depreciation.			0 31.98
31.99	Demonstration payment adjustment amount before sequestration			0 31.99
32.00	Total amount payable to the provider (see instructions)			3,346,564 32.00
32.01	Sequestration adjustment (see instructions)			66,931 32.01
32.02	Demonstration payment adjustment amount after sequestration			0 32.02
33.00	Interim payments			2,303,009 33.00
34.00	Tentative settlement (for contractor use only)			0 34.00
35.00	Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34)			976,624 35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			30,936 36.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4			48,248 50.00
51.00	Outlier reconciliation adjustment amount (see instructions)			0 51.00
52.00	The rate used to calculate the Time Value of Money			0.00 52.00
53.00	Time Value of Money (see instructions)			0 53.00
FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AND BEGINNING ON OR BEFORE MAY 11, 2023 (THE END OF THE COVID-19 PHE)				
99.00	Teaching Adjustment Factor for the cost reporting period immediately preceding February 29, 2020.			0.000000 99.00
99.01	Calculated Teaching Adjustment Factor for the current year. (see instructions)			0.000000 99.01

OUTLIER RECONCILIATION AT TENTATIVE SETTLEMENT

Provider CCN: 14-0046

Period:
From 01/01/2023
To 12/31/2023

Worksheet E-5

Date/Time Prepared:
5/21/2024 10:06 am

Title XVIII

PPS

1.00

TO BE COMPLETED BY CONTRACTOR

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

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only)

Provider CCN: 14-0046

Period:
From 01/01/2023
To 12/31/2023

Worksheet G

Date/Time Prepared:
5/21/2024 10:06 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	-3,938	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	71,376,774	0	0	0	4.00
5.00	Other receivable	2,399,398	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-40,963,984	0	0	0	6.00
7.00	Inventory	4,762,396	0	0	0	7.00
8.00	Prepaid expenses	784,065	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	38,354,711	0	0	0	11.00
FIXED ASSETS						
12.00	Land	590,251	0	0	0	12.00
13.00	Land improvements	6,943,766	0	0	0	13.00
14.00	Accumulated depreciation	-5,926,917	0	0	0	14.00
15.00	Buildings	160,843,428	0	0	0	15.00
16.00	Accumulated depreciation	-66,083,718	0	0	0	16.00
17.00	Leasehold improvements	19,336,297	0	0	0	17.00
18.00	Accumulated depreciation	-10,044,146	0	0	0	18.00
19.00	Fixed equipment	16,409,156	0	0	0	19.00
20.00	Accumulated depreciation	-11,829,481	0	0	0	20.00
21.00	Automobiles and trucks	314,614	0	0	0	21.00
22.00	Accumulated depreciation	-256,001	0	0	0	22.00
23.00	Major movable equipment	72,894,587	0	0	0	23.00
24.00	Accumulated depreciation	-55,161,413	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	128,030,423	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	4,937,562	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	5,203,089	1,283,181	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	10,140,651	1,283,181	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	176,525,785	1,283,181	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	565,947,688	0	0	0	37.00
38.00	Salaries, wages, and fees payable	5,634,574	0	0	0	38.00
39.00	Payroll taxes payable	137,946	0	0	0	39.00
40.00	Notes and loans payable (short term)	794,278	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	265,145	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	572,779,631	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	-481,362,309	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	-481,362,309	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	91,417,322	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	85,108,463				52.00
53.00	Specific purpose fund		1,283,181			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)	85,108,463	1,283,181	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	176,525,785	1,283,181	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-0046

Period:
From 01/01/2023
To 12/31/2023

Worksheet G-1

Date/Time Prepared:
5/21/2024 10:06 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		141,613,282		1,062,787		1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		43,682,704				2.00
3.00	Total (sum of line 1 and line 2)		185,295,986		1,062,787		3.00
4.00	RELEATED ORG TRANSFERS	-100,187,524		220,395		0	4.00
5.00	CORPORATE OFFICE	0		0		0	5.00
6.00	GAIN ON INVESTMENTS	0		0		0	6.00
7.00	TRANSFER FROM OTHER RELATED ORGANIZA	0		0		0	7.00
8.00	TRANSFERS FROM OTHER FUNDS	0		0		0	8.00
9.00	DONATIONS	0		0		0	9.00
10.00	Total additions (sum of line 4-9)		-100,187,524		220,395		10.00
11.00	Subtotal (line 3 plus line 10)		85,108,462		1,283,182		11.00
12.00	Deductions (debit adjustments) (speci fy)	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)		85,108,462		1,283,182		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	RELEATED ORG TRANSFERS		0				4.00
5.00	CORPORATE OFFICE		0				5.00
6.00	GAIN ON INVESTMENTS		0				6.00
7.00	TRANSFER FROM OTHER RELATED ORGANIZA		0				7.00
8.00	TRANSFERS FROM OTHER FUNDS		0				8.00
9.00	DONATIONS		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) (speci fy)		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: 14-0046

Period:
From 01/01/2023
To 12/31/2023Worksheet G-2
Parts I & II
Date/Time Prepared:
5/21/2024 10:06 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	60,615,900		60,615,900	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF	5,620,534		5,620,534	3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	66,236,434		66,236,434	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	7,297,502		7,297,502	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)	7,297,502		7,297,502	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	73,533,936		73,533,936	17.00
18.00	Ancillary services	267,086,606	315,569,896	582,656,502	18.00
19.00	Outpatient services	14,394,794	49,177,991	63,572,785	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	EMPLOYEE CHARGES	3,753,477	9,621,867	13,375,344	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	358,768,813	374,369,754	733,138,567	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		213,684,585		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)		213,684,585		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-0046

Period:
From 01/01/2023
To 12/31/2023

Worksheet G-3

Date/Time Prepared:
5/21/2024 10:06 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	733,138,567	1.00
2.00	Less contractual allowances and discounts on patients' accounts	506,650,248	2.00
3.00	Net patient revenues (line 1 minus line 2)	226,488,319	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	213,684,585	4.00
5.00	Net income from service to patients (line 3 minus line 4)	12,803,734	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	2,636,259	6.00
7.00	Income from investments	588,059	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	-520	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	642,384	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	391,485	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER INCOME	18,854,104	24.00
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (sum of lines 6-24)	23,111,771	25.00
26.00	Total (line 5 plus line 25)	35,915,505	26.00
27.00	NON OPERATING EXPENSES	-7,767,199	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	-7,767,199	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	43,682,704	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 14-0046	Period: From 01/01/2023 To 12/31/2023	Worksheet L Parts I-III Date/Time Prepared: 5/21/2024 10:06 am
		Title XVIII	Hospital	PPS
		1.00		
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		2,009,385	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		48,542	2.00
2.01	Model 4 BPCI Capital DRG outlier payments		0	2.01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)		78.21	3.00
4.00	Number of interns & residents (see instructions)		0.00	4.00
5.00	Indirect medical education percentage (see instructions)		0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)		0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		0.00	8.00
9.00	Sum of lines 7 and 8		0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)		0.00	10.00
11.00	Disproportionate share adjustment (see instructions)		0	11.00
12.00	Total prospective capital payments (see instructions)		2,057,927	12.00
		1.00		
PART II - PAYMENT UNDER REASONABLE COST				
1.00	Program inpatient routine capital cost (see instructions)		0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)		0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)		0	3.00
4.00	Capital cost payment factor (see instructions)		0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)		0	5.00
		1.00		
PART III - COMPUTATION OF EXCEPTION PAYMENTS				
1.00	Program inpatient capital costs (see instructions)		0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)		0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)		0	3.00
4.00	Applicable exception percentage (see instructions)		0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)		0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)		0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)		0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)		0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)		0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)		0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)		0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)		0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)		0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)		0	14.00
15.00	Current year allowable operating and capital payment (see instructions)		0	15.00
16.00	Current year operating and capital costs (see instructions)		0	16.00
17.00	Current year exception offset amount (see instructions)		0	17.00