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: 14-1312	Period: From 05/01/2022 To 04/30/2023	Worksheet S Parts I-III Date/Time Prepared: 8/21/2023 8:16 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 8/21/2023 Time: 8:16 am
2. [ ] Manually prepared cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no.

Contractor use only

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

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

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by ROCHELLE COMMUNITY HOSPITAL (14-1312) for the cost reporting period beginning 05/01/2022 and ending 04/30/2023 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

	SIGNATURE OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR		CHECKBOX	ELECTRONIC SIGNATURE STATEMENT	
	1		2		
1	Lori Gutierrez		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	Lori Gutierrez			2
3	Signatory Title	CHIEF FINANCIAL OFFICER			3
4	Date	(Dated when report is electronica			4

		Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	HOSPITAL	0	393,906	-317,042	0	0	1.00
2.00	SUBPROVIDER - IPF	0	0	0		0	2.00
3.00	SUBPROVIDER - IRF	0	0	0		0	3.00
5.00	SWING BED - SNF	0	0	0		0	5.00
6.00	SWING BED - NF	0				0	6.00
200.00	TOTAL	0	393,906	-317,042	0	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1312 | Period: From 05/01/2022 To 04/30/2023 | Worksheet S-2 Part I | Date/Time Prepared: 8/21/2023 8:16 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 900 NORTH 2ND STREET	PO Box:			1.00
2.00	City: ROCHELLE	State: IL	Zip Code: 61068	County: OGLE	2.00

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)			
							V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	ROCHELLE COMMUNITY HOSPITAL	141312	99914	1	05/01/2001	N	O	N	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	ROCHELLE COMMUNITY HOSPITAL	14Z312	99914		04/17/1987	N	O	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	05/01/2022	04/30/2023	20.00
21.00	Type of Control (see instructions)	2		21.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1312 | Period: From 05/01/2022 To 04/30/2023 | Worksheet S-2 Part I | Date/Time Prepared: 8/21/2023 8:16 am

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 14-1312	Period: From 05/01/2022 To 04/30/2023	Worksheet S-2 Part I Date/Time Prepared: 8/21/2023 8:16 am

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1312 | Period: From 05/01/2022 To 04/30/2023 | Worksheet S-2 Part I Date/Time Prepared: 8/21/2023 8:16 am

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 14-1312	Period: From 05/01/2022 To 04/30/2023	Worksheet S-2 Part I Date/Time Prepared: 8/21/2023 8:16 am

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

			1.00	2.00	3.00	
	Inpatient Psychiatric Facility PPS					
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.		N			70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)				0	71.00
	Inpatient Rehabilitation Facility PPS					
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.		N			75.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)				0	76.00

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

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

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

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

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

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

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

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

		1.00	2.00	3.00	
112.00	Did this hospital participate in the Pennsylvania Rural Health Model (PARHM) demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N			112.00
113.00	Did this hospital participate in the Community Health Access and Rural Transformation (CHART) model for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no.				113.00
	Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1			118.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1312 | Period: From 05/01/2022 To 04/30/2023 | Worksheet S-2 Part I | Date/Time Prepared: 8/21/2023 8:16 am

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	429,055	0	0	118.01

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 14-1312	Period: From 05/01/2022 To 04/30/2023	Worksheet S-2 Part I Date/Time Prepared: 8/21/2023 8:16 am

		1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.	N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.	N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.	N	149.00

		Part A	Part B	Title V	Title XIX	
		1.00	2.00	3.00	4.00	
	Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)					
155.00	Hospital	N	N	N	N	155.00
156.00	Subprovider - IPF	N	N	N	N	156.00
157.00	Subprovider - IRF	N	N	N	N	157.00
158.00	SUBPROVIDER					158.00
159.00	SNF	N	N	N	N	159.00
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00
161.00	CMHC		N	N	N	161.00

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 14-1312 | Period: From 05/01/2022 To 04/30/2023 | Worksheet S-2 Part II | Date/Time Prepared: 8/21/2023 8:16 am

			Y/N	Date	
			1.00	2.00	
	PART II - HOSPITAL AND HOSPITAL HEATHCARE COMPLEX REIMBURSEMENT QUESTIONNAIRE				
	General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
	COMPLETED BY ALL HOSPITALS				
	Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)		N		1.00
		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N			3.00
		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00
			Y/N	Legal Oper.	
			1.00	2.00	
	Approved Educational Activities				
6.00	Column 1: Are costs claimed for a nursing program? Column 2: If yes, is the provider the legal operator of the program?		N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.		N		7.00
8.00	Were nursing programs and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.		N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.		N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.		N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.		N		11.00
				Y/N	
				1.00	
	Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N	13.00
14.00	If line 12 is yes, were patient deductibles and/or coinsurance amounts waived? If yes, see instructions.			N	14.00
	Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N	15.00

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	05/31/2023	Y	05/31/2023	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 14-1312 | Period: From 05/01/2022 To 04/30/2023 | Worksheet S-2 Part II | Date/Time Prepared: 8/21/2023 8:16 am

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

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

		Y/N	Date	
		1.00	2.00	
	Home Office Costs			
36.00	Were home office costs claimed on the cost report?	N		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.			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.			38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			40.00

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 14-1312	Period: From 05/01/2022 To 04/30/2023	Worksheet S-2 Part II Date/Time Prepared: 8/21/2023 8:16 am

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-1312 | Period: From 05/01/2022 To 04/30/2023 | Worksheet S-3 Part I Date/Time Prepared: 8/21/2023 8:16 am

	Component	Worksheet A Line No.	No. of Beds	Bed Days Available	CAH/REH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	13	4,745	27,720.00	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)		13	4,745	27,720.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	4	1,460	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						13.00
14.00	Total (see instructions)		17	6,205	27,720.00	0	14.00
15.00	CAH visits					0	15.00
15.10	REH hours and visits						15.10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		17				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00
33.01	LTCH site neutral days and discharges						33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care	30.00	0	0		0	34.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-1312 | Period: From 05/01/2022 To 04/30/2023 | Worksheet S-3 Part I | Date/Time Prepared: 8/21/2023 8:16 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)	631	6	1,155			1.00
2.00	HMO and other (see instructions)	60	66				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	18			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)	631	6	1,173			7.00
8.00	INTENSIVE CARE UNIT	0	0	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						13.00
14.00	Total (see instructions)	631	6	1,173	0.00	309.41	14.00
15.00	CAH visits	0	0	0			15.00
15.10	REH hours and visits						15.10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	309.41	27.00
28.00	Observation Bed Days		0	1,094			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care	0	0	0			34.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-1312 | Period: From 05/01/2022 To 04/30/2023 | Worksheet S-3 Part I | Date/Time Prepared: 8/21/2023 8:16 am

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	188	3	365	1.00
2.00	HMO and other (see instructions)			15	34		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	188	3	365	14.00
15.00	CAH visits						15.00
15.10	REH hours and visits						15.10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care						34.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 14-1312 | Period: From 05/01/2022 To 04/30/2023 | Worksheet S-10 | Date/Time Prepared: 8/21/2023 8:16 am

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.385380	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	5,345,322	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?	Y	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	16,767,742	6.00
7.00	Medicaid cost (line 1 times line 6)	6,461,952	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	1,116,630	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	0	9.00
10.00	Stand-alone CHIP charges	0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	1,116,630	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
	Uncompensated Care (see instructions for each line)				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	868,320	284,748	1,153,068	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	334,633	284,748	619,381	21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	334,633	284,748	619,381	23.00

		1.00	
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	2,748,703	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	495,175	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	761,808	27.01
28.00	Non-Medicare bad debt expense (see instructions)	1,986,895	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	1,032,343	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	1,651,724	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	2,768,354	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-1312 | Period: From 05/01/2022 To 04/30/2023 | Worksheet A | Date/Time Prepared: 8/21/2023 8:16 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		937,565	937,565	190,122	1,127,687	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		3,320,895	3,320,895	62,850	3,383,745	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	228,240	6,522,037	6,750,277	0	6,750,277	4.00
5.01	00570	ADMITTING	590,671	57,746	648,417	199,891	848,308	5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE	595,924	390,859	986,783	0	986,783	5.02
5.03	00590	OTHER ADMIN & GENERAL	2,347,863	3,662,833	6,010,696	-73,120	5,937,576	5.03
7.00	00700	OPERATION OF PLANT	394,370	1,250,580	1,644,950	0	1,644,950	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	109,256	109,256	8.00
9.00	00900	HOUSEKEEPING	502,106	192,568	694,674	-105,111	589,563	9.00
10.00	01000	DIETARY	475,170	497,579	972,749	-765,456	207,293	10.00
11.00	01100	CAFETERIA	0	0	0	765,456	765,456	11.00
13.00	01300	NURSING ADMINISTRATION	284,304	68,860	353,164	0	353,164	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	174,796	123,445	298,241	-4,145	294,096	14.00
15.00	01500	PHARMACY	289,509	1,786,017	2,075,526	-1,505,284	570,242	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	619,685	119,691	739,376	0	739,376	16.00
17.00	01700	SOCIAL SERVICE	315,816	21,490	337,306	0	337,306	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,634,338	1,084,968	3,719,306	0	3,719,306	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,357,838	829,529	2,187,367	0	2,187,367	50.00
53.00	05300	ANESTHESIOLOGY	0	274,541	274,541	0	274,541	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	993,737	1,100,113	2,093,850	-49,425	2,044,425	54.00
60.00	06000	LABORATORY	997,873	2,426,478	3,424,351	-8,164	3,416,187	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	74,832	74,832	8,164	82,996	62.00
64.00	06400	INTRAVENOUS THERAPY	282,099	28,750	310,849	0	310,849	64.00
65.00	06500	RESPIRATORY THERAPY	658,796	114,369	773,165	32,864	806,029	65.00
66.00	06600	PHYSICAL THERAPY	658,597	74,823	733,420	-187,794	545,626	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	187,794	187,794	67.00
69.00	06900	ELECTROCARDIOLOGY	0	15,407	15,407	6,360	21,767	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	14,970	14,970	0	14,970	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	488,519	488,519	0	488,519	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,554,709	1,554,709	73.00
76.00	03950	DIABETIC SERVICES	47,782	6,096	53,878	0	53,878	76.00
76.97	07697	CARDIAC REHABILITATION	204,322	16,573	220,895	0	220,895	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	2,086,352	1,328,408	3,414,760	-6,360	3,408,400	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		172,507	172,507	-172,507	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	16,740,188	27,003,048	43,743,236	240,100	43,983,336	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	OCCUPATIONAL HEALTH	432,121	114,896	547,017	0	547,017	194.00
194.01	07951	FOUNDATION	0	0	0	0	0	194.01
194.02	07952	PHYSICIANS CLINICS	215,532	53,151	268,683	-232,755	35,928	194.02
194.03	07953	FAMILY HEALTHCARE	3,358,874	369,021	3,727,895	-7,345	3,720,550	194.03
200.00		TOTAL (SUM OF LINES 118 through 199)	20,746,715	27,540,116	48,286,831	0	48,286,831	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-1312 | Period: From 05/01/2022 To 04/30/2023 | Worksheet A | Date/Time Prepared: 8/21/2023 8:16 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	-149,631	978,056		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-23,267	3,360,478		2.00
3.00	00300	OTHER CAP REL COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-54,270	6,696,007		4.00
5.01	00570	ADMITTING	0	848,308		5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	986,783		5.02
5.03	00590	OTHER ADMIN & GENERAL	-1,316,610	4,620,966		5.03
7.00	00700	OPERATION OF PLANT	-1,025	1,643,925		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	109,256		8.00
9.00	00900	HOUSEKEEPING	0	589,563		9.00
10.00	01000	DIETARY	0	207,293		10.00
11.00	01100	CAFETERIA	-146,242	619,214		11.00
13.00	01300	NURSING ADMINISTRATION	-945	352,219		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	294,096		14.00
15.00	01500	PHARMACY	-18,106	552,136		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-1,927	737,449		16.00
17.00	01700	SOCIAL SERVICE	0	337,306		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-577,750	3,141,556		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-16,500	2,170,867		50.00
53.00	05300	ANESTHESIOLOGY	-268,739	5,802		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,044,425		54.00
60.00	06000	LABORATORY	0	3,416,187		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	82,996		62.00
64.00	06400	INTRAVENOUS THERAPY	0	310,849		64.00
65.00	06500	RESPIRATORY THERAPY	0	806,029		65.00
66.00	06600	PHYSICAL THERAPY	0	545,626		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	187,794		67.00
69.00	06900	ELECTROCARDIOLOGY	0	21,767		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	14,970		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	488,519		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,554,709		73.00
76.00	03950	DIABETIC SERVICES	0	53,878		76.00
76.97	07697	CARDIAC REHABILITATION	0	220,895		76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	-608,372	2,800,028		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-3,183,384	40,799,952		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
194.00	07950	OCCUPATIONAL HEALTH	0	547,017		194.00
194.01	07951	FOUNDATION	0	0		194.01
194.02	07952	PHYSICIANS CLINICS	0	35,928		194.02
194.03	07953	FAMILY HEALTHCARE	0	3,720,550		194.03
200.00		TOTAL (SUM OF LINES 118 through 199)	-3,183,384	45,103,447		200.00

RECLASSIFICATIONS | Provider CCN: 14-1312 | Period: From 05/01/2022 To 04/30/2023 | Worksheet A-6 | Date/Time Prepared: 8/21/2023 8:16 am

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - PROPERTY INSURANCE					
1.00	OTHER CAP REL COSTS	3.00	0	80,465		1.00
	0		0	80,465		
	B - CAFETERIA					
1.00	CAFETERIA	11.00	373,911	391,545		1.00
	0		373,911	391,545		
	C - RECEPTIONIST-NURSING					
1.00	ADMITTING	5.01	185,100	14,791		1.00
2.00	RESPIRATORY THERAPY	65.00	30,432	2,432		2.00
	0		215,532	17,223		
	E - INTEREST EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	149,631		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	22,876		2.00
	0		0	172,507		
	F - EKGS					
1.00	ELECTROCARDIOLOGY	69.00	6,360	0		1.00
	0		6,360	0		
	H - OCCUPATIONAL THERAPY					
1.00	OCCUPATIONAL THERAPY	67.00	168,635	19,159		1.00
	0		168,635	19,159		
	I - LAUNDRY AND LINEN					
1.00	LAUNDRY & LINEN SERVICE	8.00	0	109,256		1.00
2.00		0.00	0	0		2.00
	0		0	109,256		
	J - PHYSICIAN ADMIN COSTS					
1.00	OTHER ADMIN & GENERAL	5.03	7,345	0		1.00
	0		7,345	0		
	K - BLOOD BANK SALARIES					
1.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	62.00	8,164	0		1.00
	0		8,164	0		
	L - DRUG COSTS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	1,554,709		1.00
2.00		0.00	0	0		2.00
	0		0	1,554,709		
500.00	Grand Total: Increases		779,947	2,344,864		500.00

RECLASSIFICATIONS | Provider CCN: 14-1312 | Period: From 05/01/2022 To 04/30/2023 | Worksheet A-6 | Date/Time Prepared: 8/21/2023 8:16 am

	Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
	A - PROPERTY INSURANCE					
1.00	OTHER ADMIN & GENERAL	5.03	0	80,465	12	1.00
	0		0	80,465		
	B - CAFETERIA					
1.00	DIETARY	10.00	373,911	391,545	0	1.00
	0		373,911	391,545		
	C - RECEPTIONIST-NURSING					
1.00	PHYSICIANS CLINICS	194.02	215,532	17,223	0	1.00
2.00		0.00	0	0	0	2.00
	0		215,532	17,223		
	E - INTEREST EXPENSE					
1.00	INTEREST EXPENSE	113.00	0	172,507	11	1.00
2.00		0.00	0	0	11	2.00
	0		0	172,507		
	F - EKGS					
1.00	EMERGENCY	91.00	6,360	0	0	1.00
	0		6,360	0		
	H - OCCUPATIONAL THERAPY					
1.00	PHYSICAL THERAPY	66.00	168,635	19,159	0	1.00
	0		168,635	19,159		
	I - LAUNDRY AND LINEN					
1.00	HOUSEKEEPING	9.00	0	105,111	0	1.00
2.00	CENTRAL SERVICES & SUPPLY	14.00	0	4,145	0	2.00
	0		0	109,256		
	J - PHYSICIAN ADMIN COSTS					
1.00	FAMILY HEALTHCARE	194.03	7,345	0	0	1.00
	0		7,345	0		
	K - BLOOD BANK SALARIES					
1.00	LABORATORY	60.00	8,164	0	0	1.00
	0		8,164	0		
	L - DRUG COSTS					
1.00	PHARMACY	15.00	0	1,505,284	0	1.00
2.00	RADIOLOGY-DIAGNOSTIC	54.00	0	49,425	0	2.00
	0		0	1,554,709		
500.00	Grand Total: Decreases		779,947	2,344,864		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1312 | Period: From 05/01/2022 To 04/30/2023 | Worksheet A-7 Part I | Date/Time Prepared: 8/21/2023 8:16 am

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	3,863,109	0	0	0	2,409,231	1.00
2.00	Land Improvements	1,555,819	0	0	0	0	2.00
3.00	Buildings and Fixtures	22,253,482	0	0	0	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	4,414,013	416,697	0	416,697	27,226	5.00
6.00	Movable Equipment	12,296,880	6,991,221	0	6,991,221	23,998	6.00
7.00	HIT designated Assets	2,808,025	0	0	0	1,935,279	7.00
8.00	Subtotal (sum of lines 1-7)	47,191,328	7,407,918	0	7,407,918	4,395,734	8.00
9.00	Reconciling Items	-4,865,506	4,342,760	0	4,342,760	0	9.00
10.00	Total (line 8 minus line 9)	52,056,834	3,065,158	0	3,065,158	4,395,734	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	1,453,878	0	1.00
2.00	Land Improvements	1,555,819	0	2.00
3.00	Buildings and Fixtures	22,253,482	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	4,803,484	0	5.00
6.00	Movable Equipment	19,264,103	0	6.00
7.00	HIT designated Assets	872,746	0	7.00
8.00	Subtotal (sum of lines 1-7)	50,203,512	0	8.00
9.00	Reconciling Items	-522,746	0	9.00
10.00	Total (line 8 minus line 9)	50,726,258	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1312 | Period: From 05/01/2022 To 04/30/2023 | Worksheet A-7 Part II Date/Time Prepared: 8/21/2023 8:16 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	920,464	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	3,176,166	144,729	0	0	0	2.00
3.00	Total (sum of lines 1-2)	4,096,630	144,729	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL			
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)		
		14.00	15.00		
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2				
1.00	CAP REL COSTS-BLDG & FIXT	17,101	937,565		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	3,320,895		2.00
3.00	Total (sum of lines 1-2)	17,101	4,258,460		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1312 | Period: From 05/01/2022 To 04/30/2023 | Worksheet A-7 Part III Date/Time Prepared: 8/21/2023 8:16 am

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	25,263,179	0	25,263,179	0.503215	40,491	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	24,940,333	0	24,940,333	0.496785	39,974	2.00
3.00	Total (sum of lines 1-2)	50,203,512	0	50,203,512	1.000000	80,465	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	40,491	920,464	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	39,974	3,175,775	144,729	2.00
3.00	Total (sum of lines 1-2)	0	0	80,465	4,096,239	144,729	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	40,491	0	17,101	978,056	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	39,974	0	0	3,360,478	2.00
3.00	Total (sum of lines 1-2)	0	80,465	0	17,101	4,338,534	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-1312 | Period: From 05/01/2022 To 04/30/2023 | Worksheet A-8 | Date/Time Prepared: 8/21/2023 8:16 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-149,631	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)	B	-22,876	CAP REL COSTS-MVBLE EQUIP	2.00	11	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	-1,025	OPERATION OF PLANT	7.00	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	-1,471,361			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	0			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-146,242	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-1,927	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	EDUCATION CLASS INCOME	B	-945	NURSING ADMINISTRATION	13.00	0	33.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-1312 | Period: From 05/01/2022 To 04/30/2023 | Worksheet A-8 | Date/Time Prepared: 8/21/2023 8:16 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.01	CREDENTIALING	B	-7,600	OTHER ADMIN & GENERAL	5.03	0	33.01
33.02	MISCELLANEOUS INCOME	B	-8,284	OTHER ADMIN & GENERAL	5.03	0	33.02
33.03	FITNESS CENTER	B	-14,557	OTHER ADMIN & GENERAL	5.03	0	33.03
33.04	MARKETING EXPENSE	A	-429,421	OTHER ADMIN & GENERAL	5.03	0	33.04
33.05	LOBBYING EXPENSE	A	-16,035	OTHER ADMIN & GENERAL	5.03	0	33.05
33.06	PROPERTY TAX	A	-11,000	OTHER ADMIN & GENERAL	5.03	0	33.06
33.07	ASSESSMENT TAX	A	-815,967	OTHER ADMIN & GENERAL	5.03	0	33.07
33.08	PHYSICIAN BENEFITS	A	-19,923	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.08
33.10	TELEPHONE SERVICES	A	-2,197	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.10
33.11	TELEPHONE SERVICES	A	-7,396	OTHER ADMIN & GENERAL	5.03	0	33.11
33.12	TELEPHONE SERVICES	A	-391	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.12
33.13	MARKETING BENEFITS	A	-32,183	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.13
33.14	MISC REVENUE - DEF COMP	B	33	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.14
33.15	340B RETIAL PHARMACY COSTS	A	-18,106	PHARMACY	15.00	0	33.15
33.17	DONATIONS	A	-6,350	OTHER ADMIN & GENERAL	5.03	0	33.17
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-3,183,384				50.00

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.
(2) Basis for adjustment (see instructions).
A. Costs - if cost, including applicable overhead, can be determined.
B. Amount Received - if cost cannot be determined.
(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.
Note: See instructions for column 5 referencing to Worksheet A-7.

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 14-1312 | Period: From 05/01/2022 To 04/30/2023 | Worksheet A-8-2 | Date/Time Prepared: 8/21/2023 8:16 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	577,750	577,750	0	0	0	1.00
2.00	50.00	OPERATING ROOM	16,500	16,500	0	0	0	2.00
3.00	53.00	ANESTHESIOLOGY	268,739	268,739	0	0	0	3.00
4.00	91.00	EMERGENCY	587,504	454,376	133,128	0	0	4.00
5.00	91.00	EMERGENCY	149,485	149,485	0	0	0	5.00
6.00	91.00	EMERGENCY	4,511	4,511	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			1,604,489	1,471,361	133,128		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	50.00	OPERATING ROOM	0	0	0	0	0	2.00
3.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	3.00
4.00	91.00	EMERGENCY	0	0	0	0	0	4.00
5.00	91.00	EMERGENCY	0	0	0	0	0	5.00
6.00	91.00	EMERGENCY	0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	577,750		1.00
2.00	50.00	OPERATING ROOM	0	0	0	16,500		2.00
3.00	53.00	ANESTHESIOLOGY	0	0	0	268,739		3.00
4.00	91.00	EMERGENCY	0	0	0	454,376		4.00
5.00	91.00	EMERGENCY	0	0	0	149,485		5.00
6.00	91.00	EMERGENCY	0	0	0	4,511		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	1,471,361		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1312 | Period: From 05/01/2022 To 04/30/2023 | Worksheet B Part I | Date/Time Prepared: 8/21/2023 8:16 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	ADMITTING	
			0	1.00	2.00	4.00	5.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	978,056	978,056				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	3,360,478		3,360,478			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	6,696,007	3,005	533	6,699,545		4.00
5.01	00570	ADMITTING	848,308	5,720	1,146	256,476	1,111,650	5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE	986,783	25,433	3,600	197,017	0	5.02
5.03	00590	OTHER ADMIN & GENERAL	4,620,966	222,617	1,979,258	744,036	0	5.03
7.00	00700	OPERATION OF PLANT	1,643,925	85,149	132,041	130,382	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	109,256	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	589,563	5,682	12,273	166,000	0	9.00
10.00	01000	DIETARY	207,293	21,677	12,898	33,477	0	10.00
11.00	01100	CAFETERIA	619,214	13,790	0	123,618	0	11.00
13.00	01300	NURSING ADMINISTRATION	352,219	11,123	1,239	93,993	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	294,096	17,719	8,433	57,789	0	14.00
15.00	01500	PHARMACY	552,136	14,561	83,163	95,714	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	737,449	13,636	3,473	204,873	0	16.00
17.00	01700	SOCIAL SERVICE	337,306	1,473	0	104,411	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,141,556	95,337	152,919	870,933	63,175	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,170,867	72,081	221,691	448,912	113,543	50.00
53.00	05300	ANESTHESIOLOGY	5,802	1,541	17,968	0	15,151	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,044,425	48,622	501,198	328,537	321,652	54.00
60.00	06000	LABORATORY	3,416,187	17,864	115,258	327,206	201,973	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	82,996	2,080	0	2,699	1,666	62.00
64.00	06400	INTRAVENOUS THERAPY	310,849	10,689	8,750	93,264	5,040	64.00
65.00	06500	RESPIRATORY THERAPY	806,029	9,129	14,870	227,864	19,786	65.00
66.00	06600	PHYSICAL THERAPY	545,626	23,334	3,622	161,985	35,320	66.00
67.00	06700	OCCUPATIONAL THERAPY	187,794	4,189	651	55,752	6,343	67.00
69.00	06900	ELECTROCARDIOLOGY	21,767	0	10,225	2,103	13,594	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	14,970	0	0	0	12,115	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	488,519	0	0	0	20,666	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,554,709	0	0	0	157,490	73.00
76.00	03950	DIABETIC SERVICES	53,878	1,271	0	15,797	329	76.00
76.97	07697	CARDIAC REHABILITATION	220,895	31,298	0	67,550	2,627	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	2,800,028	65,388	50,507	638,241	121,180	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	40,799,952	824,408	3,335,716	5,448,629	1,111,650	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	4,459	0	0	0	190.00
194.00	07950	OCCUPATIONAL HEALTH	547,017	0	4,808	142,863	0	194.00
194.01	07951	FOUNDATION	0	0	0	0	0	194.01
194.02	07952	PHYSICIANS CLINICS	35,928	37,365	6,656	0	0	194.02
194.03	07953	FAMILY HEALTHCARE	3,720,550	111,824	13,298	1,108,053	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	45,103,447	978,056	3,360,478	6,699,545	1,111,650	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1312 | Period: From 05/01/2022 To 04/30/2023 | Worksheet B Part I Date/Time Prepared: 8/21/2023 8:16 am

		Cost Center Description	CASHIERING/ACCOUNTS RECEIVABLE	Subtotal	OTHER ADMIN & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
			5.02	5A.02	5.03	7.00	8.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE	1,212,833					5.02
5.03	00590	OTHER ADMIN & GENERAL	0	7,566,877	7,566,877			5.03
7.00	00700	OPERATION OF PLANT	0	1,991,497	401,460	2,392,957		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	109,256	22,025	0	131,281	8.00
9.00	00900	HOUSEKEEPING	0	773,518	155,931	21,373	0	9.00
10.00	01000	DIETARY	0	275,345	55,506	81,544	0	10.00
11.00	01100	CAFETERIA	0	756,622	152,525	51,875	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	458,574	92,443	41,841	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	378,037	76,207	66,655	0	14.00
15.00	01500	PHARMACY	0	745,574	150,298	54,773	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	959,431	193,409	51,296	0	16.00
17.00	01700	SOCIAL SERVICE	0	443,190	89,341	5,543	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	68,025	4,391,945	885,359	358,634	33,570	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	122,260	3,149,354	634,869	271,149	20,692	50.00
53.00	05300	ANESTHESIOLOGY	16,314	56,776	11,445	5,796	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	346,279	3,590,713	723,841	182,903	27,133	54.00
60.00	06000	LABORATORY	217,478	4,295,966	866,011	67,199	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	1,794	91,235	18,392	7,825	0	62.00
64.00	06400	INTRAVENOUS THERAPY	5,427	434,019	87,493	40,210	0	64.00
65.00	06500	RESPIRATORY THERAPY	21,305	1,098,983	221,541	34,342	0	65.00
66.00	06600	PHYSICAL THERAPY	38,032	807,919	162,866	87,775	7,903	66.00
67.00	06700	OCCUPATIONAL THERAPY	6,830	261,559	52,727	15,758	1,419	67.00
69.00	06900	ELECTROCARDIOLOGY	14,637	62,326	12,564	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	13,045	40,130	8,090	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	22,253	531,438	107,131	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	169,580	1,881,779	379,342	0	0	73.00
76.00	03950	DIABETIC SERVICES	354	71,629	14,439	4,782	0	76.00
76.97	07697	CARDIAC REHABILITATION	2,829	325,199	65,556	117,733	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	130,483	3,805,827	767,205	245,972	40,564	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0				92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,196,925	39,354,718	6,408,016	1,814,978	131,281	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	4,459	899	16,772	0	190.00
194.00	07950	OCCUPATIONAL HEALTH	0	694,688	140,040	0	0	194.00
194.01	07951	FOUNDATION	0	0	0	0	0	194.01
194.02	07952	PHYSICIANS CLINICS	0	79,949	16,117	140,555	0	194.02
194.03	07953	FAMILY HEALTHCARE	15,908	4,969,633	1,001,805	420,652	0	194.03
200.00		Cross Foot Adjustments		0				200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,212,833	45,103,447	7,566,877	2,392,957	131,281	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1312 | Period: From 05/01/2022 To 04/30/2023 | Worksheet B Part I Date/Time Prepared: 8/21/2023 8:16 am

		Cost Center Description	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			9.00	10.00	11.00	13.00	14.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.02
5.03	00590	OTHER ADMIN & GENERAL						5.03
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	950,822					9.00
10.00	01000	DIETARY	32,693	445,088				10.00
11.00	01100	CAFETERIA	20,798	0	981,820			11.00
13.00	01300	NURSING ADMINISTRATION	16,775	0	9,383	619,016		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	26,724	0	17,323	0	564,946	14.00
15.00	01500	PHARMACY	21,960	0	22,857	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	20,566	0	46,916	0	0	16.00
17.00	01700	SOCIAL SERVICE	2,222	0	9,143	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	143,784	366,302	161,439	234,793	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	108,710	24,991	104,418	151,870	0	50.00
53.00	05300	ANESTHESIOLOGY	2,324	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	73,330	0	59,668	0	0	54.00
60.00	06000	LABORATORY	26,941	0	105,525	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	3,137	0	866	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	16,121	15,135	25,984	37,792	0	64.00
65.00	06500	RESPIRATORY THERAPY	13,768	0	47,878	2,799	0	65.00
66.00	06600	PHYSICAL THERAPY	35,191	0	32,769	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	6,318	0	9,094	0	0	67.00
69.00	06900	ELECTROCARDIOLOGY	0	0	626	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	209,030	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	355,916	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	DIABETIC SERVICES	1,917	0	5,774	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	47,202	0	17,323	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	98,616	38,660	131,221	191,762	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	719,097	445,088	808,207	619,016	564,946	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	6,724	0	0	0	0	190.00
194.00	07950	OCCUPATIONAL HEALTH	0	0	0	0	0	194.00
194.01	07951	FOUNDATION	0	0	0	0	0	194.01
194.02	07952	PHYSICIANS CLINICS	56,352	0	0	0	0	194.02
194.03	07953	FAMILY HEALTHCARE	168,649	0	173,613	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)	950,822	445,088	981,820	619,016	564,946	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1312 | Period: From 05/01/2022 To 04/30/2023 | Worksheet B Part I | Date/Time Prepared: 8/21/2023 8:16 am

		Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			15.00	16.00	17.00	24.00	25.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.02
5.03	00590	OTHER ADMIN & GENERAL						5.03
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	995,462					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,271,618				16.00
17.00	01700	SOCIAL SERVICE	0	0	549,439			17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	226,533	549,439	7,351,798	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	44,987	0	4,511,040	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	76,341	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	31,646	77,781	0	4,767,015	0	54.00
60.00	06000	LABORATORY	0	117,303	0	5,478,945	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	121,455	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	347,913	0	1,004,667	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	6,307	0	1,425,618	0	65.00
66.00	06600	PHYSICAL THERAPY	0	39,563	0	1,173,986	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	7,105	0	353,980	0	67.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	75,516	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	257,250	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	994,485	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	963,816	0	0	3,224,937	0	73.00
76.00	03950	DIABETIC SERVICES	0	0	0	98,541	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	573,013	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	404,126	0	5,723,953	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	995,462	1,271,618	549,439	37,212,540	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	28,854	0	190.00
194.00	07950	OCCUPATIONAL HEALTH	0	0	0	834,728	0	194.00
194.01	07951	FOUNDATION	0	0	0	0	0	194.01
194.02	07952	PHYSICIANS CLINICS	0	0	0	292,973	0	194.02
194.03	07953	FAMILY HEALTHCARE	0	0	0	6,734,352	0	194.03
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	995,462	1,271,618	549,439	45,103,447	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1312 | Period: From 05/01/2022 To 04/30/2023 | Worksheet B Part I | Date/Time Prepared: 8/21/2023 8:16 am

		Cost Center Description	Total		
			26.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.01	00570	ADMITTING			5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE			5.02
5.03	00590	OTHER ADMIN & GENERAL			5.03
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
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	7,351,798		30.00
31.00	03100	INTENSIVE CARE UNIT	0		31.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	4,511,040		50.00
53.00	05300	ANESTHESIOLOGY	76,341		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,767,015		54.00
60.00	06000	LABORATORY	5,478,945		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	121,455		62.00
64.00	06400	INTRAVENOUS THERAPY	1,004,667		64.00
65.00	06500	RESPIRATORY THERAPY	1,425,618		65.00
66.00	06600	PHYSICAL THERAPY	1,173,986		66.00
67.00	06700	OCCUPATIONAL THERAPY	353,980		67.00
69.00	06900	ELECTROCARDIOLOGY	75,516		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	257,250		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	994,485		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,224,937		73.00
76.00	03950	DIABETIC SERVICES	98,541		76.00
76.97	07697	CARDIAC REHABILITATION	573,013		76.97
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0		90.00
91.00	09100	EMERGENCY	5,723,953		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	37,212,540		118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	28,854		190.00
194.00	07950	OCCUPATIONAL HEALTH	834,728		194.00
194.01	07951	FOUNDATION	0		194.01
194.02	07952	PHYSICIANS CLINICS	292,973		194.02
194.03	07953	FAMILY HEALTHCARE	6,734,352		194.03
200.00		Cross Foot Adjustments	0		200.00
201.00		Negative Cost Centers	0		201.00
202.00		TOTAL (sum lines 118 through 201)	45,103,447		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1312 | Period: From 05/01/2022 To 04/30/2023 | Worksheet B Part II Date/Time Prepared: 8/21/2023 8:16 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	3,005	533	3,538	3,538	4.00
5.01	00570	ADMITTING	0	5,720	1,146	6,866	136	5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	25,433	3,600	29,033	104	5.02
5.03	00590	OTHER ADMIN & GENERAL	0	222,617	1,979,258	2,201,875	394	5.03
7.00	00700	OPERATION OF PLANT	0	85,149	132,041	217,190	69	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	0	5,682	12,273	17,955	88	9.00
10.00	01000	DIETARY	0	21,677	12,898	34,575	18	10.00
11.00	01100	CAFETERIA	0	13,790	0	13,790	65	11.00
13.00	01300	NURSING ADMINISTRATION	0	11,123	1,239	12,362	50	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	17,719	8,433	26,152	31	14.00
15.00	01500	PHARMACY	0	14,561	83,163	97,724	51	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	13,636	3,473	17,109	108	16.00
17.00	01700	SOCIAL SERVICE	0	1,473	0	1,473	55	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	95,337	152,919	248,256	461	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	72,081	221,691	293,772	238	50.00
53.00	05300	ANESTHESIOLOGY	0	1,541	17,968	19,509	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	48,622	501,198	549,820	174	54.00
60.00	06000	LABORATORY	0	17,864	115,258	133,122	173	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	2,080	0	2,080	1	62.00
64.00	06400	INTRAVENOUS THERAPY	0	10,689	8,750	19,439	49	64.00
65.00	06500	RESPIRATORY THERAPY	0	9,129	14,870	23,999	121	65.00
66.00	06600	PHYSICAL THERAPY	0	23,334	3,622	26,956	86	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	4,189	651	4,840	30	67.00
69.00	06900	ELECTROCARDIOLOGY	0	0	10,225	10,225	1	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	DIABETIC SERVICES	0	1,271	0	1,271	8	76.00
76.97	07697	CARDIAC REHABILITATION	0	31,298	0	31,298	36	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	65,388	50,507	115,895	338	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	824,408	3,335,716	4,160,124	2,885	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	4,459	0	4,459	0	190.00
194.00	07950	OCCUPATIONAL HEALTH	0	0	4,808	4,808	76	194.00
194.01	07951	FOUNDATION	0	0	0	0	0	194.01
194.02	07952	PHYSICIANS CLINICS	0	37,365	6,656	44,021	0	194.02
194.03	07953	FAMILY HEALTHCARE	0	111,824	13,298	125,122	577	194.03
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	978,056	3,360,478	4,338,534	3,538	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1312 | Period: From 05/01/2022 To 04/30/2023 | Worksheet B Part II | Date/Time Prepared: 8/21/2023 8:16 am

		Cost Center Description	ADMITTING	CASHIERING/ACCOUNTS RECEIVABLE	OTHER ADMIN & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
			5.01	5.02	5.03	7.00	8.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING	7,002					5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	29,137				5.02
5.03	00590	OTHER ADMIN & GENERAL	0	0	2,202,269			5.03
7.00	00700	OPERATION OF PLANT	0	0	116,841	334,100		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	6,410	0	6,410	8.00
9.00	00900	HOUSEKEEPING	0	0	45,382	2,984	0	9.00
10.00	01000	DIETARY	0	0	16,154	11,385	0	10.00
11.00	01100	CAFETERIA	0	0	44,391	7,243	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	26,905	5,842	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	22,179	9,306	0	14.00
15.00	01500	PHARMACY	0	0	43,743	7,647	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	56,290	7,162	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	26,002	774	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	400	1,635	257,675	50,072	1,639	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	720	2,939	184,773	37,857	1,010	50.00
53.00	05300	ANESTHESIOLOGY	96	392	3,331	809	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,995	8,308	210,667	25,537	1,325	54.00
60.00	06000	LABORATORY	1,280	5,228	252,044	9,382	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	11	43	5,353	1,092	0	62.00
64.00	06400	INTRAVENOUS THERAPY	32	130	25,464	5,614	0	64.00
65.00	06500	RESPIRATORY THERAPY	125	512	64,477	4,795	0	65.00
66.00	06600	PHYSICAL THERAPY	224	914	47,401	12,255	386	66.00
67.00	06700	OCCUPATIONAL THERAPY	40	164	15,346	2,200	69	67.00
69.00	06900	ELECTROCARDIOLOGY	86	352	3,657	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	77	314	2,354	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	131	535	31,179	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	998	4,076	110,404	0	0	73.00
76.00	03950	DIABETIC SERVICES	2	9	4,202	668	0	76.00
76.97	07697	CARDIAC REHABILITATION	17	68	19,079	16,438	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	768	3,136	223,288	34,342	1,981	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	7,002	28,755	1,864,991	253,404	6,410	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	262	2,342	0	190.00
194.00	07950	OCCUPATIONAL HEALTH	0	0	40,757	0	0	194.00
194.01	07951	FOUNDATION	0	0	0	0	0	194.01
194.02	07952	PHYSICIANS CLINICS	0	0	4,691	19,624	0	194.02
194.03	07953	FAMILY HEALTHCARE	0	382	291,568	58,730	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)	7,002	29,137	2,202,269	334,100	6,410	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1312 | Period: From 05/01/2022 To 04/30/2023 | Worksheet B Part II | Date/Time Prepared: 8/21/2023 8:16 am

		Cost Center Description	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			9.00	10.00	11.00	13.00	14.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.02
5.03	00590	OTHER ADMIN & GENERAL						5.03
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	66,409					9.00
10.00	01000	DIETARY	2,283	64,415				10.00
11.00	01100	CAFETERIA	1,453	0	66,942			11.00
13.00	01300	NURSING ADMINISTRATION	1,172	0	640	46,971		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,866	0	1,181	0	60,715	14.00
15.00	01500	PHARMACY	1,534	0	1,558	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,436	0	3,199	0	0	16.00
17.00	01700	SOCIAL SERVICE	155	0	623	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	10,042	53,013	11,007	17,816	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	7,593	3,617	7,119	11,524	0	50.00
53.00	05300	ANESTHESIOLOGY	162	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,122	0	4,068	0	0	54.00
60.00	06000	LABORATORY	1,882	0	7,195	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	219	0	59	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	1,126	2,190	1,772	2,868	0	64.00
65.00	06500	RESPIRATORY THERAPY	962	0	3,264	212	0	65.00
66.00	06600	PHYSICAL THERAPY	2,458	0	2,234	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	441	0	620	0	0	67.00
69.00	06900	ELECTROCARDIOLOGY	0	0	43	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	22,465	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	38,250	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	DIABETIC SERVICES	134	0	394	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	3,297	0	1,181	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	6,888	5,595	8,947	14,551	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	50,225	64,415	55,104	46,971	60,715	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	470	0	0	0	0	190.00
194.00	07950	OCCUPATIONAL HEALTH	0	0	0	0	0	194.00
194.01	07951	FOUNDATION	0	0	0	0	0	194.01
194.02	07952	PHYSICIANS CLINICS	3,936	0	0	0	0	194.02
194.03	07953	FAMILY HEALTHCARE	11,778	0	11,838	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)	66,409	64,415	66,942	46,971	60,715	202.00

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		Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			15.00	16.00	17.00	24.00	25.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.02
5.03	00590	OTHER ADMIN & GENERAL						5.03
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	152,257					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	85,304				16.00
17.00	01700	SOCIAL SERVICE	0	0	29,082			17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	15,196	29,082	696,294	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	3,018	0	554,180	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	24,299	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,840	5,218	0	817,074	0	54.00
60.00	06000	LABORATORY	0	7,869	0	418,175	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	8,858	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	23,339	0	82,023	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	423	0	98,890	0	65.00
66.00	06600	PHYSICAL THERAPY	0	2,654	0	95,568	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	477	0	24,227	0	67.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	14,364	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	25,210	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	70,095	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	147,417	0	0	262,895	0	73.00
76.00	03950	DIABETIC SERVICES	0	0	0	6,688	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	71,414	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	27,110	0	442,839	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	152,257	85,304	29,082	3,713,093	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	7,533	0	190.00
194.00	07950	OCCUPATIONAL HEALTH	0	0	0	45,641	0	194.00
194.01	07951	FOUNDATION	0	0	0	0	0	194.01
194.02	07952	PHYSICIANS CLINICS	0	0	0	72,272	0	194.02
194.03	07953	FAMILY HEALTHCARE	0	0	0	499,995	0	194.03
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	152,257	85,304	29,082	4,338,534	0	202.00

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		Cost Center Description	Total		
			26.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.01	00570	ADMITTING			5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE			5.02
5.03	00590	OTHER ADMIN & GENERAL			5.03
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
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	696,294		30.00
31.00	03100	INTENSIVE CARE UNIT	0		31.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	554,180		50.00
53.00	05300	ANESTHESIOLOGY	24,299		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	817,074		54.00
60.00	06000	LABORATORY	418,175		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	8,858		62.00
64.00	06400	INTRAVENOUS THERAPY	82,023		64.00
65.00	06500	RESPIRATORY THERAPY	98,890		65.00
66.00	06600	PHYSICAL THERAPY	95,568		66.00
67.00	06700	OCCUPATIONAL THERAPY	24,227		67.00
69.00	06900	ELECTROCARDIOLOGY	14,364		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	25,210		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	70,095		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	262,895		73.00
76.00	03950	DIABETIC SERVICES	6,688		76.00
76.97	07697	CARDIAC REHABILITATION	71,414		76.97
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0		90.00
91.00	09100	EMERGENCY	442,839		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,713,093		118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	7,533		190.00
194.00	07950	OCCUPATIONAL HEALTH	45,641		194.00
194.01	07951	FOUNDATION	0		194.01
194.02	07952	PHYSICIANS CLINICS	72,272		194.02
194.03	07953	FAMILY HEALTHCARE	499,995		194.03
200.00		Cross Foot Adjustments	0		200.00
201.00		Negative Cost Centers	0		201.00
202.00		TOTAL (sum lines 118 through 201)	4,338,534		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1312 | Period: From 05/01/2022 To 04/30/2023 | Worksheet B-1 | Date/Time Prepared: 8/21/2023 8:16 am

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	ADMITTING (GROSS REVENUE)	CASHIERING/ACCOUNTS RECEIVABLE (GROSS REVENUE)	
			1.00	2.00	4.00	5.01	5.02	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	101,563					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		3,320,504				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	312	527	20,264,291			4.00
5.01	00570	ADMITTING	594	1,132	775,771	97,861,203		5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE	2,641	3,557	595,924	0	99,161,812	5.02
5.03	00590	OTHER ADMIN & GENERAL	23,117	1,955,714	2,250,509	0	0	5.03
7.00	00700	OPERATION OF PLANT	8,842	130,470	394,370	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	590	12,127	502,106	0	0	9.00
10.00	01000	DIETARY	2,251	12,745	101,259	0	0	10.00
11.00	01100	CAFETERIA	1,432	0	373,911	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,155	1,224	284,304	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,840	8,333	174,796	0	0	14.00
15.00	01500	PHARMACY	1,512	82,174	289,509	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,416	3,432	619,685	0	0	16.00
17.00	01700	SOCIAL SERVICE	153	0	315,816	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,900	151,100	2,634,338	5,561,698	5,561,698	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	7,485	219,054	1,357,838	9,995,882	9,995,882	50.00
53.00	05300	ANESTHESIOLOGY	160	17,754	0	1,333,803	1,333,803	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,049	495,236	993,737	28,312,906	28,312,906	54.00
60.00	06000	LABORATORY	1,855	113,887	989,709	17,780,911	17,780,911	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	216	0	8,164	146,676	146,676	62.00
64.00	06400	INTRAVENOUS THERAPY	1,110	8,646	282,099	443,713	443,713	64.00
65.00	06500	RESPIRATORY THERAPY	948	14,693	689,228	1,741,918	1,741,918	65.00
66.00	06600	PHYSICAL THERAPY	2,423	3,579	489,962	3,109,452	3,109,452	66.00
67.00	06700	OCCUPATIONAL THERAPY	435	643	168,635	558,452	558,452	67.00
69.00	06900	ELECTROCARDIOLOGY	0	10,103	6,360	1,196,720	1,196,720	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	1,066,517	1,066,517	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,819,382	1,819,382	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	13,864,754	13,864,754	73.00
76.00	03950	DIABETIC SERVICES	132	0	47,782	28,937	28,937	76.00
76.97	07697	CARDIAC REHABILITATION	3,250	0	204,322	231,280	231,280	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	6,790	49,906	1,930,507	10,668,202	10,668,202	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	85,608	3,296,036	16,480,641	97,861,203	97,861,203	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	463	0	0	0	0	190.00
194.00	07950	OCCUPATIONAL HEALTH	0	4,751	432,121	0	0	194.00
194.01	07951	FOUNDATION	0	0	0	0	0	194.01
194.02	07952	PHYSICIANS CLINICS	3,880	6,577	0	0	0	194.02
194.03	07953	FAMILY HEALTHCARE	11,612	13,140	3,351,529	0	1,300,609	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)	978,056	3,360,478	6,699,545	1,111,650	1,212,833	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	9.630042	1.012039	0.330608	0.011359	0.012231	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			3,538	7,002	29,137	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000175	0.000072	0.000294	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: 14-1312 | Period: From 05/01/2022 To 04/30/2023 | Worksheet B-1 | Date/Time Prepared: 8/21/2023 8:16 am

		Cost Center Description	Reconciliation	OTHER ADMIN & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	
			5A.03	5.03	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.02
5.03	00590	OTHER ADMIN & GENERAL	-7,566,877	37,536,570				5.03
7.00	00700	OPERATION OF PLANT	0	1,991,497	66,057			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	109,256	0	117,481		8.00
9.00	00900	HOUSEKEEPING	0	773,518	590	0	65,467	9.00
10.00	01000	DIETARY	0	275,345	2,251	0	2,251	10.00
11.00	01100	CAFETERIA	0	756,622	1,432	0	1,432	11.00
13.00	01300	NURSING ADMINISTRATION	0	458,574	1,155	0	1,155	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	378,037	1,840	0	1,840	14.00
15.00	01500	PHARMACY	0	745,574	1,512	0	1,512	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	959,431	1,416	0	1,416	16.00
17.00	01700	SOCIAL SERVICE	0	443,190	153	0	153	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	4,391,945	9,900	30,041	9,900	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	3,149,354	7,485	18,517	7,485	50.00
53.00	05300	ANESTHESIOLOGY	0	56,776	160	0	160	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,590,713	5,049	24,281	5,049	54.00
60.00	06000	LABORATORY	0	4,295,966	1,855	0	1,855	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	91,235	216	0	216	62.00
64.00	06400	INTRAVENOUS THERAPY	0	434,019	1,110	0	1,110	64.00
65.00	06500	RESPIRATORY THERAPY	0	1,098,983	948	0	948	65.00
66.00	06600	PHYSICAL THERAPY	0	807,919	2,423	7,072	2,423	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	261,559	435	1,270	435	67.00
69.00	06900	ELECTROCARDIOLOGY	0	62,326	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	40,130	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	531,438	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,881,779	0	0	0	73.00
76.00	03950	DIABETIC SERVICES	0	71,629	132	0	132	76.00
76.97	07697	CARDIAC REHABILITATION	0	325,199	3,250	0	3,250	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	3,805,827	6,790	36,300	6,790	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-7,566,877	31,787,841	50,102	117,481	49,512	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	4,459	463	0	463	190.00
194.00	07950	OCCUPATIONAL HEALTH	0	694,688	0	0	0	194.00
194.01	07951	FOUNDATION	0	0	0	0	0	194.01
194.02	07952	PHYSICIANS CLINICS	0	79,949	3,880	0	3,880	194.02
194.03	07953	FAMILY HEALTHCARE	0	4,969,633	11,612	0	11,612	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)		7,566,877	2,392,957	131,281	950,822	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)		0.201587	36.225638	1.117466	14.523684	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		2,202,269	334,100	6,410	66,409	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.058670	5.057753	0.054562	1.014389	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: 14-1312 | Period: From 05/01/2022 To 04/30/2023 | Worksheet B-1 | Date/Time Prepared: 8/21/2023 8:16 am

		Cost Center Description	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
			10.00	11.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.02
5.03	00590	OTHER ADMIN & GENERAL						5.03
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	7,587					10.00
11.00	01100	CAFETERIA	0	20,404				11.00
13.00	01300	NURSING ADMINISTRATION	0	195	183,973			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	360	0	100		14.00
15.00	01500	PHARMACY	0	475	0	0	1,554,709	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	975	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	190	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,244	3,355	69,781	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	426	2,170	45,136	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,240	0	0	49,425	54.00
60.00	06000	LABORATORY	0	2,193	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	18	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	258	540	11,232	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	995	832	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	681	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	189	0	0	0	67.00
69.00	06900	ELECTROCARDIOLOGY	0	13	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	37	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	63	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	1,505,284	73.00
76.00	03950	DIABETIC SERVICES	0	120	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	360	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	659	2,727	56,992	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	7,587	16,796	183,973	100	1,554,709	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	OCCUPATIONAL HEALTH	0	0	0	0	0	194.00
194.01	07951	FOUNDATION	0	0	0	0	0	194.01
194.02	07952	PHYSICIANS CLINICS	0	0	0	0	0	194.02
194.03	07953	FAMILY HEALTHCARE	0	3,608	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)	445,088	981,820	619,016	564,946	995,462	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	58.664558	48.118996	3.364711	5,649.460000	0.640288	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	64,415	66,942	46,971	60,715	152,257	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	8.490181	3.280827	0.255315	607.150000	0.097933	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: 14-1312 | Period: From 05/01/2022 To 04/30/2023 | Worksheet B-1 | Date/Time Prepared: 8/21/2023 8:16 am

		Cost Center Description	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TOTAL PATIENT DAYS)		
			16.00	17.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.01	00570	ADMITTING				5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE				5.02
5.03	00590	OTHER ADMIN & GENERAL				5.03
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	90,735			16.00
17.00	01700	SOCIAL SERVICE	0	1,155		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	16,164	1,155		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	3,210	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,550	0		54.00
60.00	06000	LABORATORY	8,370	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		62.00
64.00	06400	INTRAVENOUS THERAPY	24,825	0		64.00
65.00	06500	RESPIRATORY THERAPY	450	0		65.00
66.00	06600	PHYSICAL THERAPY	2,823	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	507	0		67.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
76.00	03950	DIABETIC SERVICES	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	28,836	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	90,735	1,155		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
194.00	07950	OCCUPATIONAL HEALTH	0	0		194.00
194.01	07951	FOUNDATION	0	0		194.01
194.02	07952	PHYSICIANS CLINICS	0	0		194.02
194.03	07953	FAMILY HEALTHCARE	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)	1,271,618	549,439		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	14.014636	475.704762		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	85,304	29,082		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.940144	25.179221		205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)				206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)				207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1312 | Period: From 05/01/2022 To 04/30/2023 | Worksheet C Part I Date/Time Prepared: 8/21/2023 8:16 am

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	Costs RCE Disallowance	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,351,798		7,351,798	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0		0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,511,040		4,511,040	0	0	50.00
53.00	05300	ANESTHESIOLOGY	76,341		76,341	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,767,015		4,767,015	0	0	54.00
60.00	06000	LABORATORY	5,478,945		5,478,945	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	121,455		121,455	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	1,004,667		1,004,667	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,425,618	0	1,425,618	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,173,986	0	1,173,986	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	353,980	0	353,980	0	0	67.00
69.00	06900	ELECTROCARDIOLOGY	75,516		75,516	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	257,250		257,250	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	994,485		994,485	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,224,937		3,224,937	0	0	73.00
76.00	03950	DIABETIC SERVICES	98,541		98,541	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	573,013		573,013	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0		0	0	0	90.00
91.00	09100	EMERGENCY	5,723,953		5,723,953	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	3,547,798		3,547,798		0	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	40,760,338	0	40,760,338	0	0	200.00
201.00		Less Observation Beds	3,547,798		3,547,798		0	201.00
202.00		Total (see instructions)	37,212,540	0	37,212,540	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1312 | Period: From 05/01/2022 To 04/30/2023 | Worksheet C Part I Date/Time Prepared: 8/21/2023 8:16 am

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,641,087		1,641,087			30.00
31.00	03100	INTENSIVE CARE UNIT	0		0			31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	568,893	9,426,989	9,995,882	0.451290	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	62,364	1,271,439	1,333,803	0.057236	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	876,933	27,435,973	28,312,906	0.168369	0.000000	54.00
60.00	06000	LABORATORY	1,340,609	16,440,302	17,780,911	0.308136	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	38,491	108,185	146,676	0.828050	0.000000	62.00
64.00	06400	INTRAVENOUS THERAPY	45,089	398,624	443,713	2.264227	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	464,986	1,276,932	1,741,918	0.818419	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	150,669	2,958,783	3,109,452	0.377554	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	82,489	475,963	558,452	0.633859	0.000000	67.00
69.00	06900	ELECTROCARDIOLOGY	24,296	1,172,424	1,196,720	0.063102	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	567,486	499,031	1,066,517	0.241206	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	124,342	1,695,040	1,819,382	0.546606	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,473,727	12,391,027	13,864,754	0.232600	0.000000	73.00
76.00	03950	DIABETIC SERVICES	0	28,937	28,937	3.405363	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	231,280	231,280	2.477573	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
91.00	09100	EMERGENCY	3,448	9,870,151	9,873,599	0.579723	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	3,414,605	3,414,605	1.039007	0.000000	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	7,464,909	89,095,685	96,560,594			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	7,464,909	89,095,685	96,560,594			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1312 | Period: From 05/01/2022 To 04/30/2023 | Worksheet C Part I Date/Time Prepared: 8/21/2023 8:16 am

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000	LABORATORY	0.000000		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000		62.00
64.00	06400	INTRAVENOUS THERAPY	0.000000		64.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.00	03950	DIABETIC SERVICES	0.000000		76.00
76.97	07697	CARDIAC REHABILITATION	0.000000		76.97
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0.000000		90.00
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 14-1312 | Period: From 05/01/2022 To 04/30/2023 | Worksheet D Part II Date/Time Prepared: 8/21/2023 8:16 am

Title XVIII | Hospital | Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	554,180	9,995,882	0.055441	293,459	16,270	50.00
53.00	05300	ANESTHESIOLOGY	24,299	1,333,803	0.018218	32,712	596	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	817,074	28,312,906	0.028859	495,638	14,304	54.00
60.00	06000	LABORATORY	418,175	17,780,911	0.023518	659,694	15,515	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	8,858	146,676	0.060392	18,568	1,121	62.00
64.00	06400	INTRAVENOUS THERAPY	82,023	443,713	0.184856	13,291	2,457	64.00
65.00	06500	RESPIRATORY THERAPY	98,890	1,741,918	0.056771	224,669	12,755	65.00
66.00	06600	PHYSICAL THERAPY	95,568	3,109,452	0.030735	90,015	2,767	66.00
67.00	06700	OCCUPATIONAL THERAPY	24,227	558,452	0.043382	54,313	2,356	67.00
69.00	06900	ELECTROCARDIOLOGY	14,364	1,196,720	0.012003	8,688	104	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	25,210	1,066,517	0.023638	227,586	5,380	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	70,095	1,819,382	0.038527	79,269	3,054	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	262,895	13,864,754	0.018961	750,825	14,236	73.00
76.00	03950	DIABETIC SERVICES	6,688	28,937	0.231123	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	71,414	231,280	0.308777	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
91.00	09100	EMERGENCY	442,839	9,873,599	0.044851	3,448	155	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	336,015	3,414,605	0.098405	0	0	92.00
200.00		Total (lines 50 through 199)	3,352,814	94,919,507		2,952,175	91,070	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1312 | Period: From 05/01/2022 To 04/30/2023 | Worksheet D Part IV Date/Time Prepared: 8/21/2023 8:16 am

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	DIABETIC SERVICES	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1312 | Period: From 05/01/2022 To 04/30/2023 | Worksheet D Part IV | Date/Time Prepared: 8/21/2023 8:16 am

Title XVIII | Hospital | Cost

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	9,995,882	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	1,333,803	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	28,312,906	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	17,780,911	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	146,676	0.000000	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	443,713	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	1,741,918	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	3,109,452	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	558,452	0.000000	67.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	1,196,720	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	1,066,517	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,819,382	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	13,864,754	0.000000	73.00
76.00	03950	DIABETIC SERVICES	0	0	0	28,937	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	231,280	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	9,873,599	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	3,414,605	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	94,919,507		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1312 | Period: From 05/01/2022 To 04/30/2023 | Worksheet D Part IV | Date/Time Prepared: 8/21/2023 8:16 am

Title XVIII | Hospital | Cost

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	293,459	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	32,712	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	495,638	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	659,694	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	18,568	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	13,291	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	224,669	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	90,015	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	54,313	0	0	0	67.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	8,688	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	227,586	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	79,269	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	750,825	0	0	0	73.00
76.00	03950	DIABETIC SERVICES	0.000000	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	3,448	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)		2,952,175	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1312 | Period: From 05/01/2022 To 04/30/2023 | Worksheet D Part V Date/Time Prepared: 8/21/2023 8:16 am

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.451290	0	2,193,480	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.057236	0	316,721	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.168369	0	7,494,226	0	0	54.00
60.00	06000	LABORATORY	0.308136	0	4,358,297	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.828050	0	74,464	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	2.264227	0	98,956	6,917	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.818419	0	414,903	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.377554	0	814,672	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.633859	0	110,714	0	0	67.00
69.00	06900	ELECTROCARDIOLOGY	0.063102	0	387,340	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.241206	0	211,494	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.546606	0	471,859	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.232600	0	6,817,419	0	0	73.00
76.00	03950	DIABETIC SERVICES	3.405363	0	6,097	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	2.477573	0	78,470	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.579723	0	2,597,235	3,615	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.039007	0	872,475	68	0	92.00
200.00		Subtotal (see instructions)		0	27,318,822	10,600	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	27,318,822	10,600	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1312 | Period: From 05/01/2022 To 04/30/2023 | Worksheet D Part V Date/Time Prepared: 8/21/2023 8:16 am

Title XVIII | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	989,896	0	50.00
53.00	05300	ANESTHESIOLOGY	18,128	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,261,795	0	54.00
60.00	06000	LABORATORY	1,342,948	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	61,660	0	62.00
64.00	06400	INTRAVENOUS THERAPY	224,059	15,662	64.00
65.00	06500	RESPIRATORY THERAPY	339,564	0	65.00
66.00	06600	PHYSICAL THERAPY	307,583	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	70,177	0	67.00
69.00	06900	ELECTROCARDIOLOGY	24,442	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	51,014	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	257,921	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,585,732	0	73.00
76.00	03950	DIABETIC SERVICES	20,762	0	76.00
76.97	07697	CARDIAC REHABILITATION	194,415	0	76.97
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0	0	90.00
91.00	09100	EMERGENCY	1,505,677	2,096	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	906,508	71	92.00
200.00		Subtotal (see instructions)	9,162,281	17,829	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	9,162,281	17,829	202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1312 | Period: From 05/01/2022 To 04/30/2023 | Worksheet D-1 | Date/Time Prepared: 8/21/2023 8:16 am

Title XVIII | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	2,267	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,249	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	1,155	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)	18	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)	631	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		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	188.44	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	208.70	20.00
21.00	Total general inpatient routine service cost (see instructions)	7,351,798	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)	58,373	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	7,293,425	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	7,293,425	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)	3,242.96	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,046,308	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)	2,046,308	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1312 | Period: From 05/01/2022 To 04/30/2023 | Worksheet D-1 | Date/Time Prepared: 8/21/2023 8:16 am

Title XVIII | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	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)	994,200	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)	3,040,508	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
55.01	Permanent adjustment amount per discharge	0.00	55.01
55.02	Adjustment amount per discharge (contractor use only)	0.00	55.02
56.00	Target amount (line 54 x sum of lines 55, 55.01, and 55.02)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)	0.00	59.00
60.00	Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)	0.00	60.00
61.00	Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	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)	1,094	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	3,242.96	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	3,547,798	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1312 | Period: From 05/01/2022 To 04/30/2023 | Worksheet D-1 | Date/Time Prepared: 8/21/2023 8:16 am

Title XVIII | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	696,294	7,351,798	0.094711	3,547,798	336,015	90.00
91.00	Nursing Program cost	0	7,351,798	0.000000	3,547,798	0	91.00
92.00	Allied health cost	0	7,351,798	0.000000	3,547,798	0	92.00
93.00	All other Medical Education	0	7,351,798	0.000000	3,547,798	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-1312 | Period: From 05/01/2022 To 04/30/2023 | Worksheet D-3 | Date/Time Prepared: 8/21/2023 8:16 am

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		883,200		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.451290	293,459	132,435	50.00
53.00	05300	ANESTHESIOLOGY	0.057236	32,712	1,872	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.168369	495,638	83,450	54.00
60.00	06000	LABORATORY	0.308136	659,694	203,275	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.828050	18,568	15,375	62.00
64.00	06400	INTRAVENOUS THERAPY	2.264227	13,291	30,094	64.00
65.00	06500	RESPIRATORY THERAPY	0.818419	224,669	183,873	65.00
66.00	06600	PHYSICAL THERAPY	0.377554	90,015	33,986	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.633859	54,313	34,427	67.00
69.00	06900	ELECTROCARDIOLOGY	0.063102	8,688	548	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.241206	227,586	54,895	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.546606	79,269	43,329	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.232600	750,825	174,642	73.00
76.00	03950	DIABETIC SERVICES	3.405363	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	2.477573	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	0	0	90.00
91.00	09100	EMERGENCY	0.579723	3,448	1,999	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.039007	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		2,952,175	994,200	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		2,952,175		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 14-1312 | Period: From 05/01/2022 To 04/30/2023 | Worksheet D-3

Component CCN: 14-Z312 | Date/Time Prepared: 8/21/2023 8:16 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.451290	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.057236	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.168369	0	0	54.00
60.00	06000	LABORATORY	0.308136	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.828050	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	2.264227	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.818419	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.377554	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.633859	0	0	67.00
69.00	06900	ELECTROCARDIOLOGY	0.063102	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.241206	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.546606	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.232600	0	0	73.00
76.00	03950	DIABETIC SERVICES	3.405363	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	2.477573	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	0	0	90.00
91.00	09100	EMERGENCY	0.579723	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.039007	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		0	0	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		0		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-1312	Period: From 05/01/2022 To 04/30/2023	Worksheet E Part B Date/Time Prepared: 8/21/2023 8:16 am
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	9,180,110	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	OPPS or REH payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	9,180,110	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (see instructions)	9,271,911	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	52,444	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	4,465,376	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)	4,754,091	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
28.50	REH facility payment amount		28.50
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27, 28, 28.50 and 29)	4,754,091	30.00
31.00	Primary payer payments	281	31.00
32.00	Subtotal (line 30 minus line 31)	4,753,810	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)	704,600	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	457,990	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	630,885	36.00
37.00	Subtotal (see instructions)	5,211,800	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50
39.75	N95 respirator payment adjustment amount (see instructions)	0	39.75
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	5,211,800	40.00
40.01	Sequestration adjustment (see instructions)	95,897	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
40.03	Sequestration adjustment-PARHM or CHART pass-throughs		40.03
41.00	Interim payments	5,432,945	41.00
41.01	Interim payments-PARHM or CHART		41.01
42.00	Tentative settlement (for contractors use only)	0	42.00
42.01	Tentative settlement-PARHM or CHART (for contractor use only)		42.01
43.00	Balance due provider/program (see instructions)	-317,042	43.00
43.01	Balance due provider/program-PARHM (see instructions)		43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-1312	Period: From 05/01/2022 To 04/30/2023	Worksheet E Part B Date/Time Prepared: 8/21/2023 8:16 am
	Title XVIII	Hospital	Cost

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-1312 | Period: From 05/01/2022 To 04/30/2023 | Worksheet E-1 Part I Date/Time Prepared: 8/21/2023 8:16 am

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		2,159,926		5,309,845	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	12/19/2022	267,300	12/19/2022	123,100	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)		267,300		123,100	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)		2,427,226		5,432,945	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		393,906		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		317,042	6.02
7.00	Total Medicare program liability (see instructions)		2,821,132		5,115,903	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: 14-1312 | Component CCN: 14-Z312 | Period: From 05/01/2022 To 04/30/2023 | Worksheet E-1 Part I | Date/Time Prepared: 8/21/2023 8:16 am

Title XVIII | Swing Beds - SNF | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		0		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		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)		0		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		0		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: 14-1312	Period: From 05/01/2022 To 04/30/2023	Worksheet E-1 Part II Date/Time Prepared: 8/21/2023 8:16 am
	Title XVIII	Hospital	Cost

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

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS | Provider CCN: 14-1312 | Component CCN: 14-Z312 | Period: From 05/01/2022 To 04/30/2023 | Worksheet E-2 | Date/Time Prepared: 8/21/2023 8:16 am

Title XVIII | Swing Beds - SNF | Cost

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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-1312	Period: From 05/01/2022 To 04/30/2023	Worksheet E-3 Part V Date/Time Prepared: 8/21/2023 8:16 am
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	3,040,508	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)	0	2.00
3.00	Organ acquisition	0	3.00
3.01	Cellular therapy acquisition cost (see instructions)	0	3.01
4.00	Subtotal (sum of lines 1 through 3.01)	3,040,508	4.00
5.00	Primary payer payments	224	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	3,070,689	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
7.00	Routine service charges	0	7.00
8.00	Ancillary service charges	0	8.00
9.00	Organ acquisition charges, net of revenue	0	9.00
10.00	Total reasonable charges	0	10.00
	Customary charges		
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13.00
14.00	Total customary charges (see instructions)	0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)	0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)	0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)	0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)	3,070,689	19.00
20.00	Deductibles (exclude professional component)	233,860	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	2,836,829	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	2,836,829	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	57,208	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	37,185	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	52,742	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	2,874,014	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	29.50
29.98	Recovery of accelerated depreciation.	0	29.98
29.99	Demonstration payment adjustment amount before sequestration	0	29.99
30.00	Subtotal (see instructions)	2,874,014	30.00
30.01	Sequestration adjustment (see instructions)	52,882	30.01
30.02	Demonstration payment adjustment amount after sequestration	0	30.02
30.03	Sequestration adjustment-PARHM or CHART		30.03
31.00	Interim payments	2,427,226	31.00
31.01	Interim payments-PARHM or CHART		31.01
32.00	Tentative settlement (for contractor use only)	0	32.00
32.01	Tentative settlement-PARHM or CHART (for contractor use only)		32.01
33.00	Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32)	393,906	33.00
33.01	Balance due provider/program-PARHM or CHART (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01)		33.01
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	34.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 14-1312 | Period: From 05/01/2022 To 04/30/2023 | Worksheet G | Date/Time Prepared: 8/21/2023 8:16 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	21,573,780	0	0	0	1.00
2.00	Temporary investments	19,440,552	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	5,769,407	0	0	0	4.00
5.00	Other receivable	839,934	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	394,552	0	0	0	7.00
8.00	Prepaid expenses	1,228,953	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	18,244	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	49,265,422	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	1,453,878	0	0	0	12.00
13.00	Land improvements	1,555,819	0	0	0	13.00
14.00	Accumulated depreciation	-1,210,665	0	0	0	14.00
15.00	Buildings	22,253,483	0	0	0	15.00
16.00	Accumulated depreciation	-14,127,078	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	4,803,484	0	0	0	19.00
20.00	Accumulated depreciation	-2,987,907	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	19,264,103	0	0	0	23.00
24.00	Accumulated depreciation	-11,181,987	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	872,746	0	0	0	27.00
28.00	Accumulated depreciation	-872,746	0	0	0	28.00
29.00	Minor equipment-nondepreciable	522,746	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	20,345,876	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	118,808	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	809,287	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	928,095	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	70,539,393	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	713,965	0	0	0	37.00
38.00	Salaries, wages, and fees payable	3,510,734	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	740,828	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	158,005	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	5,123,532	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	5,061,929	0	0	0	47.00
48.00	Unsecured loans	112,838	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	5,174,767	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	10,298,299	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	60,241,094				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	60,241,094	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	70,539,393	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 14-1312 | Period: From 05/01/2022 To 04/30/2023 | Worksheet G-1 | Date/Time Prepared: 8/21/2023 8:16 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		57,469,379		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		2,771,715				2.00
3.00	Total (sum of line 1 and line 2)		60,241,094		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		60,241,094		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		60,241,094		0		19.00

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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 14-1312 | Period: From 05/01/2022 To 04/30/2023 | Worksheet G-2 Parts I & II Date/Time Prepared: 8/21/2023 8:16 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	1,599,400		1,599,400	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	24,969		24,969	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)	1,624,369		1,624,369	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	16,718		16,718	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)	16,718		16,718	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	1,641,087		1,641,087	17.00
18.00	Ancillary services	5,820,238	76,221,963	82,042,201	18.00
19.00	Outpatient services	3,448	13,668,577	13,672,025	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PROFESSIONAL FEES	0	505,890	505,890	27.00
27.01	PRIVATE PHYSICIAN OFFICES	0	5,122,908	5,122,908	27.01
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	7,464,773	95,519,338	102,984,111	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		48,286,831		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)		48,286,831		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 14-1312 | Period: From 05/01/2022 To 04/30/2023 | Worksheet G-3 | Date/Time Prepared: 8/21/2023 8:16 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	102,984,111	1.00
2.00	Less contractual allowances and discounts on patients' accounts	52,588,168	2.00
3.00	Net patient revenues (line 1 minus line 2)	50,395,943	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	48,286,831	4.00
5.00	Net income from service to patients (line 3 minus line 4)	2,109,112	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	2,377	6.00
7.00	Income from investments	588,283	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	146,242	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	1,927	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	16,975	22.00
23.00	Governmental appropriations	0	23.00
24.00	MISCELLANEOUS INCOME	42,226	24.00
24.01	340B	24,239	24.01
24.02	GRANTS	69,620	24.02
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (sum of lines 6-24)	891,889	25.00
26.00	Total (line 5 plus line 25)	3,001,001	26.00
27.00	LOSS ON INVESTMENTS	229,286	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	229,286	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	2,771,715	29.00