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: 15-1314	Period: From 07/01/2022 To 06/30/2023	Worksheet S Parts I-III Date/Time Prepared: 11/22/2023 7:41 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 11/22/2023 Time: 7:41 pm
2. [ ] Manually prepared cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no.

Contractor use only

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

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

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by ASCENSION ST VINCENT SALEM (15-1314) for the cost reporting period beginning 07/01/2022 and ending 06/30/2023 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	Chris Hons		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	Chris Hons			2
3	Signatory Title	VP OF FINANCE			3
4	Date	11/22/2023 07:41:46 PM			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	-29,314	-457,950	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	-23,315	0		0	5.00
6.00	SWING BED - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		0		0	10.00
11.00	FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0	11.00
200.00	TOTAL	0	-52,629	-457,950	0	0	200.00

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-1314	Period: From 07/01/2022 To 06/30/2023	Worksheet S-2 Part I Date/Time Prepared: 11/22/2023 7:41 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 911 N. SHELBY STREET	PO Box:			1.00
2.00	City: SALEM	State: IN	Zip Code: 47167	County: WASHINGTON	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	ASCENSION ST VINCENT SALEM	151314	31140	1	12/01/2002	N	O	O	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	ASCENSION ST VINCENT SALEM SWING	15Z314	31140		12/01/2002	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)	07/01/2022	06/30/2023	20.00
21.00	Type of Control (see instructions)	1		21.00

		1.00	2.00	3.00	
	Inpatient PPS Information				
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	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.	2	N		23.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1314 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-2 Part I | Date/Time Prepared: 11/22/2023 7:41 pm

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

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

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

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

		V	XVIII	XIX	
		1.00	2.00	3.00	
	Prospective Payment System (PPS)-Capital				
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y for yes or "N" for no.	N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00
	Teaching Hospitals				
56.00	Is this a hospital involved in training residents in approved GME programs? For cost reporting periods beginning prior to December 27, 2020, enter "Y" for yes or "N" for no in column 1. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.78(b)(2), see the instructions. For column 2, if the response to column 1 is "Y", or if this hospital was involved in training residents in approved GME programs in the prior year or penultimate year, and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter "Y" for yes; otherwise, enter "N" for no in column 2.	N			56.00
57.00	For cost reporting periods beginning prior to December 27, 2020, if line 56, column 1, is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.77(e)(1)(iv) and (v), regardless of which month(s) of the cost report the residents were on duty, if the response to line 56 is "Y" for yes, enter "Y" for yes in column 1, do not complete column 2, and complete Worksheet E-4.				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: 15-1314 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-2 Part I Date/Time Prepared: 11/22/2023 7:41 pm

		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: 15-1314 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-2 Part I | Date/Time Prepared: 11/22/2023 7:41 pm

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

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/(col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	65.00

		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/(col. 1 + col. 2))	
		1.00	2.00	3.00	
	Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010				
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	66.00

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/(col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	67.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-1314	Period: From 07/01/2022 To 06/30/2023	Worksheet S-2 Part I Date/Time Prepared: 11/22/2023 7:41 pm

		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.	N	0	88.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1314 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-2 Part I Date/Time Prepared: 11/22/2023 7:41 pm

		V	XIX	
		1.00	2.00	
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	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.	N	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.	N	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.	N	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.	N	N	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.	Y	Y	N	N	109.00

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1314 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-2 Part I Date/Time Prepared: 11/22/2023 7:41 pm

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	111,783	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.	Y	5.00	122.00
123.00	Did the facility and/or its subproviders (if applicable) purchase professional services, e.g., legal, accounting, tax preparation, bookkeeping, payroll, and/or management/consulting services, from an unrelated organization? In column 1, enter "Y" for yes or "N" for no. If column 1 is "Y", were the majority of the expenses, i.e., greater than 50% of total professional services expenses, for services purchased from unrelated organizations located in a CBSA outside of the main hospital CBSA? In column 2, enter "Y" for yes or "N" for no.			123.00
	Certified Transplant Center Information			
125.00	Does this facility operate a Medicare-certified transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare-certified kidney transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare-certified heart transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare-certified liver transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare-certified lung transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare-certified pancreas transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare-certified intestinal transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare-certified islet transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	Removed and reserved			133.00
134.00	If this is a hospital-based organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	15H046	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: ASCENSION ST. VINCENT	Contractor's Name: WPS	Contractor's Number: 08001	141.00
142.00	Street: 250 WEST 96TH STREET SUITE 215	PO Box:		142.00
143.00	City: NDIANAPOLIS	State: IN	Zip Code: 46290	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: 15-1314 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-2 Part I Date/Time Prepared: 11/22/2023 7:41 pm

					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)			N	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: 15-1314 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-2 Part II | Date/Time Prepared: 11/22/2023 7:41 pm

			Y/N	Date	
			1.00	2.00	
	PART II - HOSPITAL AND HOSPITAL HEATHCARE COMPLEX REIMBURSEMENT QUESTIONNAIRE				
	General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
	COMPLETED BY ALL HOSPITALS				
	Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)		N		1.00
		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y			3.00
		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00
			Y/N	Legal Oper.	
			1.00	2.00	
	Approved Educational Activities				
6.00	Column 1: Are costs claimed for a nursing program? Column 2: If yes, is the provider the legal operator of the program?		N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.		N		7.00
8.00	Were nursing programs and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.		N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.		N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.		N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.		N		11.00
				Y/N	
				1.00	
	Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N	13.00
14.00	If line 12 is yes, were patient deductibles and/or coinsurance amounts waived? If yes, see instructions.			N	14.00
	Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N	15.00
		Part A		Part B	
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
	PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	10/06/2023	Y	10/06/2023	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: 15-1314 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-2 Part II | Date/Time Prepared: 11/22/2023 7:41 pm

		Description		Y/N	Y/N	
		0		1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				N	27.00
	Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				Y	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				N	31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				N	33.00
	Provider-Based Physicians					
34.00	Were services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				N	35.00
				Y/N	Date	
				1.00	2.00	
	Home Office Costs					
36.00	Were home office costs claimed on the cost report?			Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			Y		37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			N		40.00
		1.00		2.00		
	Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	JILL		HILL		41.00
42.00	Enter the employer/company name of the cost report preparer.	ASCENSION				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	(317) 583-3519		JILL.HILL1@ASCENSION.ORG		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-1314	Period: From 07/01/2022 To 06/30/2023	Worksheet S-2 Part II Date/Time Prepared: 11/22/2023 7:41 pm

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1314 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-3 Part I Date/Time Prepared: 11/22/2023 7:41 pm

	Component	Worksheet A Line No.	No. of Beds	Bed Days Available	CAH/REH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	25	9,125	4,032.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		25	9,125	4,032.00	0	7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		25	9,125	4,032.00	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	88.00				0	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		25				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00
33.01	LTCH site neutral days and discharges						33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care	30.00	0	0		0	34.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1314 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-3 Part I | Date/Time Prepared: 11/22/2023 7:41 pm

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	55	2	168			1.00
2.00	HMO and other (see instructions)	24	20				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	8	0	51			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	31			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	63	2	250			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)	63	2	250	0.00	50.51	14.00
15.00	CAH visits	6,659	741	31,686			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	0	0	0	0.00	0.00	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	50.51	27.00
28.00	Observation Bed Days		0	190			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: 15-1314 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-3 Part I | Date/Time Prepared: 11/22/2023 7:41 pm

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	23	2	64	1.00
2.00	HMO and other (see instructions)			10	6		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	23	2	64	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	0.00					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: 15-1314 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-10 | Date/Time Prepared: 11/22/2023 7:41 pm

		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)	0.255175	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	2,325,247	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	N	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?		4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	18,488,841	6.00
7.00	Medicaid cost (line 1 times line 6)	4,717,890	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)	2,392,643	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)	2,392,643	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)	707,177	525,339	1,232,516	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	180,454	525,339	705,793	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)	180,454	525,339	705,793	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)	1,808,065	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	365,446	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	562,225	27.01
28.00	Non-Medicare bad debt expense (see instructions)	1,245,840	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	514,686	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	1,220,479	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	3,613,122	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1314 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A | Date/Time Prepared: 11/22/2023 7:41 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		572,571	572,571	0	572,571	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		363,253	363,253	0	363,253	2.00
3.00	00300	OTHER CAP RELATED COST		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	132,372	1,084,482	1,216,854	0	1,216,854	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	321,832	4,438,785	4,760,617	0	4,760,617	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	35,886	35,886	0	35,886	6.00
7.00	00700	OPERATION OF PLANT	0	1,186,274	1,186,274	0	1,186,274	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	63,724	63,724	0	63,724	8.00
9.00	00900	HOUSEKEEPING	0	442,123	442,123	0	442,123	9.00
10.00	01000	DIETARY	0	378,545	378,545	-337,837	40,708	10.00
11.00	01100	CAFETERIA	0	0	0	337,837	337,837	11.00
13.00	01300	NURSING ADMINISTRATION	192,910	35,897	228,807	0	228,807	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	11,113	12,387	23,500	0	23,500	14.00
15.00	01500	PHARMACY	221,940	-125,629	96,311	0	96,311	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	767,082	39,487	806,569	-146	806,423	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	539,789	264,986	804,775	-73,072	731,703	50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	845,491	163,881	1,009,372	-952	1,008,420	54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	1,389,264	1,389,264	0	1,389,264	60.00
61.00	06100	PBP CLINICAL LAB. SERVICE-PRGM. ONLY		0	0	0	0	61.00
65.00	06500	RESPIRATORY THERAPY	25,736	5,384	31,120	0	31,120	65.00
66.00	06600	PHYSICAL THERAPY	22,867	768,051	790,918	-109,399	681,519	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	109,399	109,399	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	204,415	9,274	213,689	0	213,689	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	24,125	24,125	79,924	104,049	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	52,912	52,912	0	52,912	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	579,879	579,879	0	579,879	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	03950	SLEEP DISORDER	78,802	63,067	141,869	0	141,869	75.01
75.03	07501	ADULT MENTAL HEALTH	0	349,454	349,454	0	349,454	75.03
76.97	07697	CARDIAC REHABILITATION	90,328	6,789	97,117	0	97,117	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	911,801	1,105,260	2,017,061	-5,754	2,011,307	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	37,027	37,027	0	37,027	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	4,366,478	13,347,138	17,713,616	0	17,713,616	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	159,466	1,089	160,555	0	160,555	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	OTHER NONREIMBURSABLE COSTS	0	0	0	0	0	193.01
193.02	19302	NEW HORIZON OP	0	0	0	0	0	193.02
200.00		TOTAL (SUM OF LINES 118 through 199)	4,525,944	13,348,227	17,874,171	0	17,874,171	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1314 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A | Date/Time Prepared: 11/22/2023 7:41 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	0	572,571		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	363,253		2.00
3.00	00300	OTHER CAP RELATED COST	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	53,391	1,270,245		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-695,469	4,065,148		5.00
6.00	00600	MAINTENANCE & REPAIRS	0	35,886		6.00
7.00	00700	OPERATION OF PLANT	0	1,186,274		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	63,724		8.00
9.00	00900	HOUSEKEEPING	0	442,123		9.00
10.00	01000	DIETARY	0	40,708		10.00
11.00	01100	CAFETERIA	-54,319	283,518		11.00
13.00	01300	NURSING ADMINISTRATION	-2,220	226,587		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	23,500		14.00
15.00	01500	PHARMACY	-32,263	64,048		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-140,400	666,023		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-42,793	688,910		50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	-119,078	889,342		54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
60.00	06000	LABORATORY	0	1,389,264		60.00
61.00	06100	PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0	0		61.00
65.00	06500	RESPIRATORY THERAPY	0	31,120		65.00
66.00	06600	PHYSICAL THERAPY	0	681,519		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	109,399		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	-62,926	150,763		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	-38,761	65,288		71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	52,912		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	579,879		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0		75.00
75.01	03950	SLEEP DISORDER	0	141,869		75.01
75.03	07501	ADULT MENTAL HEALTH	0	349,454		75.03
76.97	07697	CARDIAC REHABILITATION	0	97,117		76.97
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0		89.00
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	2,011,307		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	37,027		95.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-1,134,838	16,578,778		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0		190.00
191.00	19100	RESEARCH	0	0		191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	160,555		192.00
193.00	19300	NONPAID WORKERS	0	0		193.00
193.01	19301	OTHER NONREIMBURSABLE COSTS	0	0		193.01
193.02	19302	NEW HORIZON OP	0	0		193.02
200.00		TOTAL (SUM OF LINES 118 through 199)	-1,134,838	16,739,333		200.00

RECLASSIFICATIONS | Provider CCN: 15-1314 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A-6 | Date/Time Prepared: 11/22/2023 7:41 pm

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - CAFETERIA					
1.00	CAFETERIA	11.00	0	337,837		1.00
	TOTALS		0	337,837		
	B - BILLABLE MEDICAL SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00		79,924		1.00
2.00						2.00
3.00						3.00
4.00						4.00
			0	79,924		
	C - PT/OT					
1.00	OCCUPATIONAL THERAPY	67.00	3,163	106,236		1.00
			3,163	106,236		
500.00	Grand Total: Increases		3,163	523,997		500.00

RECLASSIFICATIONS | Provider CCN: 15-1314 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A-6 | Date/Time Prepared: 11/22/2023 7:41 pm

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - CAFETERIA						
1.00	DIETARY	10.00	0	337,837	0		1.00
	TOTALS		0	337,837			
	B - BILLABLE MEDICAL SUPPLIES						
1.00	ADULTS & PEDIATRICS	30.00		146			1.00
2.00	OPERATING ROOM	50.00		73,072			2.00
3.00	RADIOLOGY - DIAGNOSTIC	54.00		952			3.00
4.00	EMERGENCY	91.00		5,754			4.00
			0	79,924			
	C - PT/OT						
1.00	PHYSICAL THERAPY	66.00	3,163	106,236			1.00
			3,163	106,236			
500.00	Grand Total: Decreases		3,163	523,997			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1314 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A-7 Part I | Date/Time Prepared: 11/22/2023 7:41 pm

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	180,000	0	0	0	0	1.00
2.00	Land Improvements	0	0	0	0	0	2.00
3.00	Buildings and Fixtures	3,041,722	166,873	0	166,873	0	3.00
4.00	Building Improvements	859,079	0	0	0	0	4.00
5.00	Fixed Equipment	1,878,154	0	0	0	0	5.00
6.00	Movable Equipment	3,246,101	181,746	0	181,746	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	9,205,056	348,619	0	348,619	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	9,205,056	348,619	0	348,619	0	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	180,000	0	1.00
2.00	Land Improvements	0	0	2.00
3.00	Buildings and Fixtures	3,208,595	0	3.00
4.00	Building Improvements	859,079	0	4.00
5.00	Fixed Equipment	1,878,154	0	5.00
6.00	Movable Equipment	3,427,847	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	9,553,675	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	9,553,675	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1314 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A-7 Part II | Date/Time Prepared: 11/22/2023 7:41 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	339,253	0	0	0	233,318	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	319,647	43,606	0	0	0	2.00
3.00	Total (sum of lines 1-2)	658,900	43,606	0	0	233,318	3.00

	Cost Center Description	SUMMARY OF CAPITAL		
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
		14.00	15.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	572,571	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	363,253	2.00
3.00	Total (sum of lines 1-2)	0	935,824	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1314 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A-7 Part III Date/Time Prepared: 11/22/2023 7:41 pm

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	6,125,829	0	6,125,829	0.641201	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	3,427,846	0	3,427,846	0.358799	0	2.00
3.00	Total (sum of lines 1-2)	9,553,675	0	9,553,675	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	339,253	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	319,647	43,606	2.00
3.00	Total (sum of lines 1-2)	0	0	0	658,900	43,606	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	0	233,318	0	572,571	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	363,253	2.00
3.00	Total (sum of lines 1-2)	0	0	233,318	0	935,824	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1314 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A-8 | Date/Time Prepared: 11/22/2023 7:41 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)	B	-7,753	ADMINISTRATIVE & GENERAL	5.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-302,271			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	575,932			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-54,319	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients	B	-32,263	PHARMACY	15.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	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	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	BUILDING RENTAL INCOME	B	-62,926	ELECTROCARDIOLOGY	69.00	0	33.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1314 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A-8 | Date/Time Prepared: 11/22/2023 7:41 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.01	PROVIDER TAX ADJUSTMENT	A	-958,014	ADMINISTRATIVE & GENERAL	5.00	0	33.01
33.02	MEDICAL RECORDS FOR SPN	A	-1,729	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03	LOBBYING	A	-510	ADMINISTRATIVE & GENERAL	5.00	0	33.03
33.06	IC PHYSICIAN FUND	A	-257,185	ADMINISTRATIVE & GENERAL	5.00	0	33.06
33.07	IC PHYSICIAN FUND	A	-33,800	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.07
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-1,134,838				50.00

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 15-1314 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A-8-1 | Date/Time Prepared: 11/22/2023 7:41 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	5.00	ADMINISTRATIVE & GENERAL	Home Office - Capital	207,056	0	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	Home Office - Interest	7,753	0	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	Home Office - Other	2,575,461	2,229,246	3.00
3.01	15.00	PHARMACY	SVH Chargebacks	4,000	4,000	3.01
3.02	4.00	EMPLOYEE BENEFITS DEPARTMENT	HEALTH INSURANCE	690,157	602,966	3.02
3.03	71.00	MEDICAL SUPPLIES CHARGED TO	TRG ADMIN FEES - SUPPLIES	-38,761	0	3.03
3.04	13.00	NURSING ADMINISTRATION	TRG ADMIN FEES - CONTRACTED	-2,220	0	3.04
3.05	5.00	ADMINISTRATIVE & GENERAL	TRG ADMIN FEES - OTHER	-31,302	0	3.05
3.06	0.00			0	0	3.06
3.07	0.00			0	0	3.07
4.00	0.00			0	0	4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			3,412,144	2,836,212	5.00

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

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

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

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

6.00	G	ASCENSION SVH	100.00	ASCENSION SVH	100.00	6.00
7.00	G	ASCENSION	100.00	ASCENSION	100.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:	HOME OFFICE				100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 15-1314	Period: From 07/01/2022 To 06/30/2023	Worksheet A-8-1 Date/Time Prepared: 11/22/2023 7:41 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	207,056	0		1.00
2.00	7,753	0		2.00
3.00	346,215	0		3.00
3.01	0	0		3.01
3.02	87,191	0		3.02
3.03	-38,761	0		3.03
3.04	-2,220	0		3.04
3.05	-31,302	0		3.05
3.06	0	0		3.06
3.07	0	0		3.07
4.00	0	0		4.00
5.00	575,932			5.00

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

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

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

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

6.00	ADMINISTRATION		6.00
7.00	ADMINISTRATION		7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 15-1314 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A-8-2 | Date/Time Prepared: 11/22/2023 7:41 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	140,400	140,400	0	0	0	1.00
2.00	50.00	OPERATING ROOM	42,793	42,793	0	0	0	2.00
3.00	54.00	RADIOLOGY - DIAGNOSTIC	119,078	119,078	0	0	0	3.00
4.00	91.00	EMERGENCY	936,436	0	936,436	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			1,238,707	302,271	936,436		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	54.00	RADIOLOGY - DIAGNOSTIC	0	0	0	0	0	3.00
4.00	91.00	EMERGENCY	0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	140,400		1.00
2.00	50.00	OPERATING ROOM	0	0	0	42,793		2.00
3.00	54.00	RADIOLOGY - DIAGNOSTIC	0	0	0	119,078		3.00
4.00	91.00	EMERGENCY	0	0	0	0		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	302,271		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 15-1314 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 11/22/2023 7:41 pm

Physical Therapy | Cost

						1.00	
	PART I - GENERAL INFORMATION						
1.00	Total number of weeks worked (excluding aides) (see instructions)					50	1.00
2.00	Line 1 multiplied by 15 hours per week					750	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					109	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					130	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					9.57	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	653.00	3,879.00	3,180.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	110.02	95.67	62.19	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	47.84	47.84	31.10			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
						1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION						
14.00	Supervisors (column 1, line 9 times column 1, line 10)					71,843	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					371,104	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)					197,764	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					640,711	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					640,711	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.						
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					0	22.00
23.00	Total salary equivalency (see instructions)					640,711	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE						
	Standard Travel Allowance						
24.00	Therapists (line 3 times column 2, line 11)					5,215	24.00
25.00	Assistants (line 4 times column 3, line 11)					4,043	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					9,258	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					2,287	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					11,545	28.00
	Optional Travel Allowance and Optional Travel Expense						
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					11,545	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE						
	Standard Travel Expense						
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
	Optional Travel Allowance and Optional Travel Expense						
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.						
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 15-1314 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 11/22/2023 7:41 pm

Physical Therapy | Cost

						1.00	
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	95.67	62.19	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

		1.00	
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT		
57.00	Salary equivalency amount (from line 23)	640,711	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	11,545	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)	0	59.00
60.00	Overtime allowance (from column 5, line 56)	0	60.00
61.00	Equipment cost (see instructions)	0	61.00
62.00	Supplies (see instructions)	0	62.00
63.00	Total allowance (sum of lines 57-62)	652,256	63.00
64.00	Total cost of outside supplier services (from your records)	651,586	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	0	65.00
	LINE 33 CALCULATION		
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	9,258	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	2,287	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	11,545	100.02
	LINE 34 CALCULATION		
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	2,287	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	101.01
101.02	Line 34 = sum of lines 27 and 31	2,287	101.02
	LINE 35 CALCULATION		
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0	102.01
102.02	Line 35 = sum of lines 31 and 32	0	102.02

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	Provider CCN: 15-1314	Period: From 07/01/2022 To 06/30/2023	Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/22/2023 7:41 pm

		Occupational Therapy	Cost	
			1.00	
	PART I - GENERAL INFORMATION			
1.00	Total number of weeks worked (excluding aides) (see instructions)		44	1.00
2.00	Line 1 multiplied by 15 hours per week		660	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)		66	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)		25	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)		0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)		0	6.00
7.00	Standard travel expense rate		9.57	7.00
8.00	Optional travel expense rate per mile		0.00	8.00

		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	1,405.00	279.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	90.69	62.58	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	45.35	45.35	31.29			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01

		1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION		
14.00	Supervisors (column 1, line 9 times column 1, line 10)	0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)	127,419	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)	17,460	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)	144,879	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)	0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)	0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)	144,879	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.		
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)	0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)	0	22.00
23.00	Total salary equivalency (see instructions)	144,879	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE		
	Standard Travel Allowance		
24.00	Therapists (line 3 times column 2, line 11)	2,993	24.00
25.00	Assistants (line 4 times column 3, line 11)	782	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)	3,775	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)	871	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)	4,646	28.00
	Optional Travel Allowance and Optional Travel Expense		
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)	0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)	0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)	0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)	0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)	4,646	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)	0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)	0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE		
	Standard Travel Expense		
36.00	Therapists (line 5 times column 2, line 11)	0	36.00
37.00	Assistants (line 6 times column 3, line 11)	0	37.00
38.00	Subtotal (sum of lines 36 and 37)	0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)	0	39.00
	Optional Travel Allowance and Optional Travel Expense		
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)	0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)	0	41.00
42.00	Subtotal (sum of lines 40 and 41)	0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)	0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.		
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)	0	44.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 15-1314 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/22/2023 7:41 pm

		Occupational Therapy	Cost	
			1.00	
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)		0	45.00
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)		0	46.00

		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	90.69	62.58	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

		1.00	
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT		
57.00	Salary equivalency amount (from line 23)	144,879	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	4,646	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)	0	59.00
60.00	Overtime allowance (from column 5, line 56)	0	60.00
61.00	Equipment cost (see instructions)	0	61.00
62.00	Supplies (see instructions)	0	62.00
63.00	Total allowance (sum of lines 57-62)	149,525	63.00
64.00	Total cost of outside supplier services (from your records)	104,594	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	0	65.00
	LINE 33 CALCULATION		
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	3,775	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	871	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	4,646	100.02
	LINE 34 CALCULATION		
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	871	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	101.01
101.02	Line 34 = sum of lines 27 and 31	871	101.02
	LINE 35 CALCULATION		
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0	102.01
102.02	Line 35 = sum of lines 31 and 32	0	102.02

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1314 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B Part I Date/Time Prepared: 11/22/2023 7:41 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	572,571	572,571				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	363,253		363,253			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,270,245	6,699	0	1,276,944		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	4,065,148	64,491	15,864	93,537	4,239,040	5.00
6.00	00600	MAINTENANCE & REPAIRS	35,886	0	0	0	35,886	6.00
7.00	00700	OPERATION OF PLANT	1,186,274	93,603	5,408	0	1,285,285	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	63,724	0	0	0	63,724	8.00
9.00	00900	HOUSEKEEPING	442,123	17,572	452	0	460,147	9.00
10.00	01000	DIETARY	40,708	55,301	2,369	0	98,378	10.00
11.00	01100	CAFETERIA	283,518	0	0	0	283,518	11.00
13.00	01300	NURSING ADMINISTRATION	226,587	2,185	1,412	56,067	286,251	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	23,500	0	0	3,230	26,730	14.00
15.00	01500	PHARMACY	64,048	5,634	41,792	64,504	175,978	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	26,756	0	0	26,756	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	666,023	63,666	12,959	222,944	965,592	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	688,910	61,286	97,070	156,884	1,004,150	50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	889,342	37,178	131,884	245,733	1,304,137	54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	1,389,264	10,734	0	0	1,399,998	60.00
61.00	06100	PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0				0	61.00
65.00	06500	RESPIRATORY THERAPY	31,120	6,208	3,319	7,480	48,127	65.00
66.00	06600	PHYSICAL THERAPY	681,519	13,013	1,336	5,727	701,595	66.00
67.00	06700	OCCUPATIONAL THERAPY	109,399	2,480	0	919	112,798	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	150,763	15,972	21,624	59,411	247,770	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	65,288	0	0	0	65,288	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	52,912	0	0	0	52,912	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	579,879	0	0	0	579,879	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	03950	SLEEP DISORDER	141,869	16,190	508	22,903	181,470	75.01
75.03	07501	ADULT MENTAL HEALTH	349,454	13,314	0	0	362,768	75.03
76.97	07697	CARDIAC REHABILITATION	97,117	2,731	1,543	26,253	127,644	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	2,011,307	25,675	25,713	265,005	2,327,700	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	37,027	0	0	0	37,027	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	16,578,778	540,688	363,253	1,230,597	16,500,548	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	160,555	28,160	0	46,347	235,062	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	OTHER NONREIMBURSABLE COSTS	0	0	0	0	0	193.01
193.02	19302	NEW HORIZON OP	0	3,723	0	0	3,723	193.02
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)	16,739,333	572,571	363,253	1,276,944	16,739,333	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1314 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B Part I Date/Time Prepared: 11/22/2023 7:41 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	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
5.00	00500	ADMINISTRATIVE & GENERAL	4,239,040					5.00
6.00	00600	MAINTENANCE & REPAIRS	12,169	48,055				6.00
7.00	00700	OPERATION OF PLANT	435,859	8,972	1,730,116			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	21,610	0	0	85,334		8.00
9.00	00900	HOUSEKEEPING	156,043	1,684	74,553	0	692,427	9.00
10.00	01000	DIETARY	33,361	5,300	234,631	0	0	10.00
11.00	01100	CAFETERIA	96,145	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	97,072	209	9,269	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	9,065	0	0	0	0	14.00
15.00	01500	PHARMACY	59,677	540	23,905	0	17,910	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	9,073	2,564	113,520	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	327,447	6,102	270,123	85,334	97,873	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	340,522	5,874	260,026	0	124,106	50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	442,252	3,563	157,737	0	92,071	54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	474,760	1,029	45,541	0	29,513	60.00
61.00	06100	PBP CLINICAL LAB. SERVICE-PRGM. ONLY						61.00
65.00	06500	RESPIRATORY THERAPY	16,321	595	26,341	0	0	65.00
66.00	06600	PHYSICAL THERAPY	237,921	1,247	55,211	0	29,009	66.00
67.00	06700	OCCUPATIONAL THERAPY	38,251	238	10,522	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	84,023	1,531	67,767	0	89,801	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	22,140	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	17,943	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	196,646	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	03950	SLEEP DISORDER	61,539	1,552	68,689	0	24,973	75.01
75.03	07501	ADULT MENTAL HEALTH	123,020	1,276	56,488	0	28,757	75.03
76.97	07697	CARDIAC REHABILITATION	43,286	262	11,586	0	14,883	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	789,363	2,461	108,933	0	120,576	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	12,556	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	4,158,064	44,999	1,594,842	85,334	669,472	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	79,713	2,699	119,479	0	22,955	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	OTHER NONREIMBURSABLE COSTS	0	0	0	0	0	193.01
193.02	19302	NEW HORIZON OP	1,263	357	15,795	0	0	193.02
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)	4,239,040	48,055	1,730,116	85,334	692,427	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1314 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B Part I Date/Time Prepared: 11/22/2023 7:41 pm

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			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
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	371,670					10.00
11.00	01100	CAFETERIA	0	379,663				11.00
13.00	01300	NURSING ADMINISTRATION	0	17,448	410,249			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,200	2,130	39,125		14.00
15.00	01500	PHARMACY	0	15,853	0	335	294,198	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	371,670	69,227	130,042	1,123	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	55,843	100,774	13,244	0	50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0	70,153	0	2,247	0	54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
61.00	06100	PBP CLINICAL LAB. SERVICE-PRGM. ONLY						61.00
65.00	06500	RESPIRATORY THERAPY	0	2,702	0	156	0	65.00
66.00	06600	PHYSICAL THERAPY	0	2,314	0	789	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	371	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	24,012	15,828	197	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	9,104	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	4,630	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	294,198	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	03950	SLEEP DISORDER	0	10,865	324	169	0	75.01
75.03	07501	ADULT MENTAL HEALTH	0	0	0	18	0	75.03
76.97	07697	CARDIAC REHABILITATION	0	8,530	15,408	79	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	80,925	145,743	6,957	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	371,670	359,443	410,249	39,048	294,198	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	20,220	0	77	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	OTHER NONREIMBURSABLE COSTS	0	0	0	0	0	193.01
193.02	19302	NEW HORIZON OP	0	0	0	0	0	193.02
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)	371,670	379,663	410,249	39,125	294,198	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1314 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B Part I Date/Time Prepared: 11/22/2023 7:41 pm

		Cost Center Description	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			16.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	151,913					16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	30,468	2,355,001	0	2,355,001		30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	24,578	1,929,117	0	1,929,117		50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	30,876	2,103,036	0	2,103,036		54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0		58.00
60.00	06000	LABORATORY	0	1,950,841	0	1,950,841		60.00
61.00	06100	PBP CLINICAL LAB. SERVICE-PRGM. ONLY		0		0		61.00
65.00	06500	RESPIRATORY THERAPY	1,189	95,431	0	95,431		65.00
66.00	06600	PHYSICAL THERAPY	1,182	1,029,268	0	1,029,268		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	162,180	0	162,180		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	10,568	541,497	0	541,497		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	96,532	0	96,532		71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	75,485	0	75,485		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,070,723	0	1,070,723		73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0		74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0		75.00
75.01	03950	SLEEP DISORDER	4,782	354,363	0	354,363		75.01
75.03	07501	ADULT MENTAL HEALTH	0	572,327	0	572,327		75.03
76.97	07697	CARDIAC REHABILITATION	3,754	225,432	0	225,432		76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0		89.00
90.00	09000	CLINIC	0	0	0	0		90.00
91.00	09100	EMERGENCY	35,617	3,618,275	0	3,618,275		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	49,583	0	49,583		95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	143,014	16,229,091	0	16,229,091		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0		190.00
191.00	19100	RESEARCH	0	0	0	0		191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	8,899	489,104	0	489,104		192.00
193.00	19300	NONPAID WORKERS	0	0	0	0		193.00
193.01	19301	OTHER NONREIMBURSABLE COSTS	0	0	0	0		193.01
193.02	19302	NEW HORIZON OP	0	21,138	0	21,138		193.02
200.00		Cross Foot Adjustments		0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	151,913	16,739,333	0	16,739,333		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1314 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B Part II Date/Time Prepared: 11/22/2023 7:41 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	6,699	0	6,699	6,699	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	207,056	64,491	15,864	287,411	491	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	0	93,603	5,408	99,011	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	0	17,572	452	18,024	0	9.00
10.00	01000	DIETARY	0	55,301	2,369	57,670	0	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	2,185	1,412	3,597	294	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	17	14.00
15.00	01500	PHARMACY	0	5,634	41,792	47,426	338	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	26,756	0	26,756	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	63,666	12,959	76,625	1,170	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	61,286	97,070	158,356	823	50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0	37,178	131,884	169,062	1,289	54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	10,734	0	10,734	0	60.00
61.00	06100	PBP CLINICAL LAB. SERVICE-PRGM. ONLY				0		61.00
65.00	06500	RESPIRATORY THERAPY	0	6,208	3,319	9,527	39	65.00
66.00	06600	PHYSICAL THERAPY	0	13,013	1,336	14,349	30	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	2,480	0	2,480	5	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	15,972	21,624	37,596	312	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	03950	SLEEP DISORDER	0	16,190	508	16,698	120	75.01
75.03	07501	ADULT MENTAL HEALTH	0	13,314	0	13,314	0	75.03
76.97	07697	CARDIAC REHABILITATION	0	2,731	1,543	4,274	138	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	25,675	25,713	51,388	1,390	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	207,056	540,688	363,253	1,110,997	6,456	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	28,160	0	28,160	243	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	OTHER NONREIMBURSABLE COSTS	0	0	0	0	0	193.01
193.02	19302	NEW HORIZON OP	0	3,723	0	3,723	0	193.02
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)	207,056	572,571	363,253	1,142,880	6,699	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1314 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B Part II Date/Time Prepared: 11/22/2023 7:41 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	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
5.00	00500	ADMINISTRATIVE & GENERAL	287,902					5.00
6.00	00600	MAINTENANCE & REPAIRS	827	827				6.00
7.00	00700	OPERATION OF PLANT	29,603	156	128,770			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,468	0	0	1,468		8.00
9.00	00900	HOUSEKEEPING	10,598	29	5,549	0	34,200	9.00
10.00	01000	DIETARY	2,266	91	17,463	0	0	10.00
11.00	01100	CAFETERIA	6,530	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	6,593	4	690	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	616	0	0	0	0	14.00
15.00	01500	PHARMACY	4,053	9	1,779	0	885	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	616	44	8,449	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	22,240	105	20,106	1,468	4,834	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	23,128	101	19,353	0	6,130	50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	30,037	61	11,740	0	4,548	54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	32,245	18	3,390	0	1,458	60.00
61.00	06100	PBP CLINICAL LAB. SERVICE-PRGM. ONLY						61.00
65.00	06500	RESPIRATORY THERAPY	1,108	10	1,960	0	0	65.00
66.00	06600	PHYSICAL THERAPY	16,159	21	4,109	0	1,433	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,598	4	783	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	5,707	26	5,044	0	4,435	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,504	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	1,219	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	13,356	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	03950	SLEEP DISORDER	4,180	27	5,112	0	1,233	75.01
75.03	07501	ADULT MENTAL HEALTH	8,355	22	4,204	0	1,420	75.03
76.97	07697	CARDIAC REHABILITATION	2,940	5	862	0	735	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	53,603	42	8,108	0	5,955	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	853	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	282,402	775	118,701	1,468	33,066	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	5,414	46	8,893	0	1,134	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	OTHER NONREIMBURSABLE COSTS	0	0	0	0	0	193.01
193.02	19302	NEW HORIZON OP	86	6	1,176	0	0	193.02
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)	287,902	827	128,770	1,468	34,200	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1314 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B Part II Date/Time Prepared: 11/22/2023 7:41 pm

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			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
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	77,490					10.00
11.00	01100	CAFETERIA	0	6,530				11.00
13.00	01300	NURSING ADMINISTRATION	0	300	11,478			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	21	60	714		14.00
15.00	01500	PHARMACY	0	273	0	6	54,769	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	77,490	1,191	3,638	21	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	960	2,819	242	0	50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0	1,207	0	41	0	54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
61.00	06100	PBP CLINICAL LAB. SERVICE-PRGM. ONLY						61.00
65.00	06500	RESPIRATORY THERAPY	0	46	0	3	0	65.00
66.00	06600	PHYSICAL THERAPY	0	40	0	14	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	6	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	413	443	4	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	166	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	85	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	54,769	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	03950	SLEEP DISORDER	0	187	9	3	0	75.01
75.03	07501	ADULT MENTAL HEALTH	0	0	0	0	0	75.03
76.97	07697	CARDIAC REHABILITATION	0	147	431	1	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	1,391	4,078	127	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	77,490	6,182	11,478	713	54,769	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	348	0	1	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	OTHER NONREIMBURSABLE COSTS	0	0	0	0	0	193.01
193.02	19302	NEW HORIZON OP	0	0	0	0	0	193.02
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)	77,490	6,530	11,478	714	54,769	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1314 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B Part II Date/Time Prepared: 11/22/2023 7:41 pm

		Cost Center Description	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			16.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	35,865					16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,193	216,081	0	216,081		30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,803	217,715	0	217,715		50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	7,289	225,274	0	225,274		54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0		58.00
60.00	06000	LABORATORY	0	47,845	0	47,845		60.00
61.00	06100	PBP CLINICAL LAB. SERVICE-PRGM. ONLY						61.00
65.00	06500	RESPIRATORY THERAPY	281	12,974	0	12,974		65.00
66.00	06600	PHYSICAL THERAPY	279	36,434	0	36,434		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	5,876	0	5,876		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	2,495	56,475	0	56,475		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,670	0	1,670		71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	1,304	0	1,304		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	68,125	0	68,125		73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0		74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0		75.00
75.01	03950	SLEEP DISORDER	1,129	28,698	0	28,698		75.01
75.03	07501	ADULT MENTAL HEALTH	0	27,315	0	27,315		75.03
76.97	07697	CARDIAC REHABILITATION	886	10,419	0	10,419		76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0		89.00
90.00	09000	CLINIC	0	0	0	0		90.00
91.00	09100	EMERGENCY	8,409	134,491	0	134,491		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	853	0	853		95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	33,764	1,091,549	0	1,091,549		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0		190.00
191.00	19100	RESEARCH	0	0	0	0		191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,101	46,340	0	46,340		192.00
193.00	19300	NONPAID WORKERS	0	0	0	0		193.00
193.01	19301	OTHER NONREIMBURSABLE COSTS	0	0	0	0		193.01
193.02	19302	NEW HORIZON OP	0	4,991	0	4,991		193.02
200.00		Cross Foot Adjustments		0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	35,865	1,142,880	0	1,142,880		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1314 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B-1 | Date/Time Prepared: 11/22/2023 7:41 pm

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (COSTED REQUIS.)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	102,740					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		362,640				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,202	0	4,393,572			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	11,572	15,837	321,832	-4,239,040	12,500,293	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	35,886	6.00
7.00	00700	OPERATION OF PLANT	16,796	5,399	0	0	1,285,285	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	63,724	8.00
9.00	00900	HOUSEKEEPING	3,153	451	0	0	460,147	9.00
10.00	01000	DIETARY	9,923	2,365	0	0	98,378	10.00
11.00	01100	CAFETERIA	0	0	0	0	283,518	11.00
13.00	01300	NURSING ADMINISTRATION	392	1,410	192,910	0	286,251	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	11,113	0	26,730	14.00
15.00	01500	PHARMACY	1,011	41,721	221,940	0	175,978	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,801	0	0	0	26,756	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	11,424	12,937	767,082	0	965,592	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	10,997	96,906	539,789	0	1,004,150	50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	6,671	131,662	845,491	0	1,304,137	54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	1,926	0	0	0	1,399,998	60.00
61.00	06100	PBP CLINICAL LAB. SERVICE-PRGM. ONLY				0		61.00
65.00	06500	RESPIRATORY THERAPY	1,114	3,313	25,736	0	48,127	65.00
66.00	06600	PHYSICAL THERAPY	2,335	1,334	19,704	0	701,595	66.00
67.00	06700	OCCUPATIONAL THERAPY	445	0	3,163	0	112,798	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	2,866	21,588	204,415	0	247,770	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	65,288	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	52,912	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	579,879	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	03950	SLEEP DISORDER	2,905	507	78,802	0	181,470	75.01
75.03	07501	ADULT MENTAL HEALTH	2,389	0	0	0	362,768	75.03
76.97	07697	CARDIAC REHABILITATION	490	1,540	90,328	0	127,644	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	4,607	25,670	911,801	0	2,327,700	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	37,027	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	97,019	362,640	4,234,106	-4,239,040	12,261,508	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	5,053	0	159,466	0	235,062	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	OTHER NONREIMBURSABLE COSTS	0	0	0	0	0	193.01
193.02	19302	NEW HORIZON OP	668	0	0	0	3,723	193.02
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)	572,571	363,253	1,276,944		4,239,040	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	5.573010	1.001690	0.290639		0.339115	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			6,699		287,902	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.001525		0.023032	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: 15-1314 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B-1 | Date/Time Prepared: 11/22/2023 7:41 pm

		Cost Center Description	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (TOTAL PATIENT DAYS)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	
			6.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS	89,966					6.00
7.00	00700	OPERATION OF PLANT	16,796	73,170				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	168			8.00
9.00	00900	HOUSEKEEPING	3,153	3,153	0	2,745		9.00
10.00	01000	DIETARY	9,923	9,923	0	0	2,421	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	392	392	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	1,011	1,011	0	71	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,801	4,801	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	11,424	11,424	168	388	2,421	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	10,997	10,997	0	492	0	50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	6,671	6,671	0	365	0	54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	1,926	1,926	0	117	0	60.00
61.00	06100	PBP CLINICAL LAB. SERVICE-PRGM. ONLY						61.00
65.00	06500	RESPIRATORY THERAPY	1,114	1,114	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	2,335	2,335	0	115	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	445	445	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	2,866	2,866	0	356	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	03950	SLEEP DISORDER	2,905	2,905	0	99	0	75.01
75.03	07501	ADULT MENTAL HEALTH	2,389	2,389	0	114	0	75.03
76.97	07697	CARDIAC REHABILITATION	490	490	0	59	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	4,607	4,607	0	478	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	84,245	67,449	168	2,654	2,421	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	5,053	5,053	0	91	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	OTHER NONREIMBURSABLE COSTS	0	0	0	0	0	193.01
193.02	19302	NEW HORIZON OP	668	668	0	0	0	193.02
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)	48,055	1,730,116	85,334	692,427	371,670	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.534146	23.645155	507.940476	252.250273	153.519207	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	827	128,770	1,468	34,200	77,490	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.009192	1.759874	8.738095	12.459016	32.007435	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: 15-1314 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B-1 | Date/Time Prepared: 11/22/2023 7:41 pm

		Cost Center Description	CAFETERIA (HOURS)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	93,020					11.00
13.00	01300	NURSING ADMINISTRATION	4,275	55,675				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	294	289	447,136			14.00
15.00	01500	PHARMACY	3,884	0	3,825	100		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	84,567	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	16,961	17,648	12,837	0	16,961	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	13,682	13,676	151,351	0	13,682	50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	17,188	0	25,680	0	17,188	54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
61.00	06100	PBP CLINICAL LAB. SERVICE-PRGM. ONLY						61.00
65.00	06500	RESPIRATORY THERAPY	662	0	1,784	0	662	65.00
66.00	06600	PHYSICAL THERAPY	567	0	9,020	0	658	66.00
67.00	06700	OCCUPATIONAL THERAPY	91	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	5,883	2,148	2,250	0	5,883	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	104,049	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	52,912	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	100	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	03950	SLEEP DISORDER	2,662	44	1,931	0	2,662	75.01
75.03	07501	ADULT MENTAL HEALTH	0	0	203	0	0	75.03
76.97	07697	CARDIAC REHABILITATION	2,090	2,091	899	0	2,090	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	19,827	19,779	79,512	0	19,827	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	88,066	55,675	446,253	100	79,613	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	4,954	0	883	0	4,954	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	OTHER NONREIMBURSABLE COSTS	0	0	0	0	0	193.01
193.02	19302	NEW HORIZON OP	0	0	0	0	0	193.02
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)	379,663	410,249	39,125	294,198	151,913	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	4.081520	7.368639	0.087501	2,941.980000	1.796363	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	6,530	11,478	714	54,769	35,865	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.070200	0.206161	0.001597	547.690000	0.424102	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: 15-1314 | Period: From 07/01/2022 To 06/30/2023 | Worksheet C Part I Date/Time Prepared: 11/22/2023 7:41 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,355,001		2,355,001	0	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,929,117		1,929,117	0	0	50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	2,103,036		2,103,036	0	0	54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0		0	0	0	58.00
60.00	06000	LABORATORY	1,950,841		1,950,841	0	0	60.00
61.00	06100	PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0		0	0	0	61.00
65.00	06500	RESPIRATORY THERAPY	95,431	0	95,431	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,029,268	0	1,029,268	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	162,180	0	162,180	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	541,497		541,497	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0		0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	96,532		96,532	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	75,485		75,485	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,070,723		1,070,723	0	0	73.00
74.00	07400	RENAL DIALYSIS	0		0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0		0	0	0	75.00
75.01	03950	SLEEP DISORDER	354,363		354,363	0	0	75.01
75.03	07501	ADULT MENTAL HEALTH	572,327		572,327	0	0	75.03
76.97	07697	CARDIAC REHABILITATION	225,432		225,432	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0		0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	89.00
90.00	09000	CLINIC	0		0	0	0	90.00
91.00	09100	EMERGENCY	3,618,275		3,618,275	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,090,404		1,090,404		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	49,583		49,583	0	0	95.00
200.00		Subtotal (see instructions)	17,319,495	0	17,319,495	0	0	200.00
201.00		Less Observation Beds	1,090,404		1,090,404		0	201.00
202.00		Total (see instructions)	16,229,091	0	16,229,091	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1314 | Period: From 07/01/2022 To 06/30/2023 | Worksheet C Part I Date/Time Prepared: 11/22/2023 7:41 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	611,626		611,626			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	116,948	8,536,365	8,653,313	0.222934	0.000000	50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	66,192	14,064,953	14,131,145	0.148823	0.000000	54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0.000000	0.000000	58.00
60.00	06000	LABORATORY	141,386	11,089,814	11,231,200	0.173698	0.000000	60.00
61.00	06100	PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0	0	0	0.000000	0.000000	61.00
65.00	06500	RESPIRATORY THERAPY	1,991	901,432	903,423	0.105633	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	56,247	2,673,717	2,729,964	0.377026	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	13,314	424,904	438,218	0.370090	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	10,625	2,361,122	2,371,747	0.228311	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	52,645	1,069,227	1,121,872	0.086045	0.000000	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	13,807	241,174	254,981	0.296042	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	105,637	3,385,711	3,491,348	0.306679	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0.000000	0.000000	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0.000000	0.000000	75.00
75.01	03950	SLEEP DISORDER	0	1,087,335	1,087,335	0.325900	0.000000	75.01
75.03	07501	ADULT MENTAL HEALTH	0	1,292,182	1,292,182	0.442915	0.000000	75.03
76.97	07697	CARDIAC REHABILITATION	0	324,765	324,765	0.694139	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0			88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0			89.00
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
91.00	09100	EMERGENCY	60,948	14,573,749	14,634,697	0.247239	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	43,352	278,720	322,072	3.385591	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
200.00		Subtotal (see instructions)	1,294,718	62,305,170	63,599,888			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	1,294,718	62,305,170	63,599,888			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1314 | Period: From 07/01/2022 To 06/30/2023 | Worksheet C Part I Date/Time Prepared: 11/22/2023 7:41 pm

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS		30.00
	ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000	50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0.000000	54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	58.00
60.00	06000	LABORATORY	0.000000	60.00
61.00	06100	PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0.000000	61.00
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0.000000	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	75.00
75.01	03950	SLEEP DISORDER	0.000000	75.01
75.03	07501	ADULT MENTAL HEALTH	0.000000	75.03
76.97	07697	CARDIAC REHABILITATION	0.000000	76.97
	OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER		89.00
90.00	09000	CLINIC	0.000000	90.00
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	92.00
	OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0.000000	95.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1314 | Period: From 07/01/2022 To 06/30/2023 | Worksheet C Part I Date/Time Prepared: 11/22/2023 7:41 pm

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,355,001		2,355,001	0	2,355,001	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,929,117		1,929,117	0	1,929,117	50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	2,103,036		2,103,036	0	2,103,036	54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0		0	0	0	58.00
60.00	06000	LABORATORY	1,950,841		1,950,841	0	1,950,841	60.00
61.00	06100	PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0		0	0	0	61.00
65.00	06500	RESPIRATORY THERAPY	95,431	0	95,431	0	95,431	65.00
66.00	06600	PHYSICAL THERAPY	1,029,268	0	1,029,268	0	1,029,268	66.00
67.00	06700	OCCUPATIONAL THERAPY	162,180	0	162,180	0	162,180	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	541,497		541,497	0	541,497	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0		0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	96,532		96,532	0	96,532	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	75,485		75,485	0	75,485	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,070,723		1,070,723	0	1,070,723	73.00
74.00	07400	RENAL DIALYSIS	0		0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0		0	0	0	75.00
75.01	03950	SLEEP DISORDER	354,363		354,363	0	354,363	75.01
75.03	07501	ADULT MENTAL HEALTH	572,327		572,327	0	572,327	75.03
76.97	07697	CARDIAC REHABILITATION	225,432		225,432	0	225,432	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0		0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	89.00
90.00	09000	CLINIC	0		0	0	0	90.00
91.00	09100	EMERGENCY	3,618,275		3,618,275	0	3,618,275	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,090,404		1,090,404		1,090,404	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	49,583		49,583	0	49,583	95.00
200.00		Subtotal (see instructions)	17,319,495	0	17,319,495	0	17,319,495	200.00
201.00		Less Observation Beds	1,090,404		1,090,404		1,090,404	201.00
202.00		Total (see instructions)	16,229,091	0	16,229,091	0	16,229,091	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1314 | Period: From 07/01/2022 To 06/30/2023 | Worksheet C Part I Date/Time Prepared: 11/22/2023 7:41 pm

Title XIX | 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	611,626		611,626			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	116,948	8,536,365	8,653,313	0.222934	0.000000	50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	66,192	14,064,953	14,131,145	0.148823	0.000000	54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0.000000	0.000000	58.00
60.00	06000	LABORATORY	141,386	11,089,814	11,231,200	0.173698	0.000000	60.00
61.00	06100	PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0	0	0	0.000000	0.000000	61.00
65.00	06500	RESPIRATORY THERAPY	1,991	901,432	903,423	0.105633	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	56,247	2,673,717	2,729,964	0.377026	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	13,314	424,904	438,218	0.370090	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	10,625	2,361,122	2,371,747	0.228311	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	52,645	1,069,227	1,121,872	0.086045	0.000000	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	13,807	241,174	254,981	0.296042	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	105,637	3,385,711	3,491,348	0.306679	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0.000000	0.000000	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0.000000	0.000000	75.00
75.01	03950	SLEEP DISORDER	0	1,087,335	1,087,335	0.325900	0.000000	75.01
75.03	07501	ADULT MENTAL HEALTH	0	1,292,182	1,292,182	0.442915	0.000000	75.03
76.97	07697	CARDIAC REHABILITATION	0	324,765	324,765	0.694139	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0.000000	0.000000	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.000000	0.000000	89.00
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
91.00	09100	EMERGENCY	60,948	14,573,749	14,634,697	0.247239	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	43,352	278,720	322,072	3.385591	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
200.00		Subtotal (see instructions)	1,294,718	62,305,170	63,599,888			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	1,294,718	62,305,170	63,599,888			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1314 | Period: From 07/01/2022 To 06/30/2023 | Worksheet C Part I Date/Time Prepared: 11/22/2023 7:41 pm

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS		30.00
	ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000	50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0.000000	54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	58.00
60.00	06000	LABORATORY	0.000000	60.00
61.00	06100	PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0.000000	61.00
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0.000000	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	75.00
75.01	03950	SLEEP DISORDER	0.000000	75.01
75.03	07501	ADULT MENTAL HEALTH	0.000000	75.03
76.97	07697	CARDIAC REHABILITATION	0.000000	76.97
	OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0.000000	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	89.00
90.00	09000	CLINIC	0.000000	90.00
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	92.00
	OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0.000000	95.00
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: 15-1314 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D Part II Date/Time Prepared: 11/22/2023 7:41 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	217,715	8,653,313	0.025160	0	0	50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	225,274	14,131,145	0.015942	654	10	54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0	0	58.00
60.00	06000	LABORATORY	47,845	11,231,200	0.004260	30,743	131	60.00
61.00	06100	PBP CLINICAL LAB. SERVICE-PRGM. ONLY						61.00
65.00	06500	RESPIRATORY THERAPY	12,974	903,423	0.014361	1,625	23	65.00
66.00	06600	PHYSICAL THERAPY	36,434	2,729,964	0.013346	7,302	97	66.00
67.00	06700	OCCUPATIONAL THERAPY	5,876	438,218	0.013409	1,754	24	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	56,475	2,371,747	0.023812	10,625	253	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,670	1,121,872	0.001489	10,202	15	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	1,304	254,981	0.005114	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	68,125	3,491,348	0.019513	51,901	1,013	73.00
74.00	07400	RENAL DIALYSIS	0	0	0.000000	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0.000000	0	0	75.00
75.01	03950	SLEEP DISORDER	28,698	1,087,335	0.026393	0	0	75.01
75.03	07501	ADULT MENTAL HEALTH	27,315	1,292,182	0.021139	0	0	75.03
76.97	07697	CARDIAC REHABILITATION	10,419	324,765	0.032082	0	0	76.97
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
91.00	09100	EMERGENCY	134,491	14,634,697	0.009190	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	100,049	322,072	0.310642	229	71	92.00
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	974,664	62,988,262		115,035	1,637	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1314 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D Part IV Date/Time Prepared: 11/22/2023 7:41 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0	0	0	0	0	54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
61.00	06100	PBP CLINICAL LAB. SERVICE-PRGM. ONLY						61.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	03950	SLEEP DISORDER	0	0	0	0	0	75.01
75.03	07501	ADULT MENTAL HEALTH	0	0	0	0	0	75.03
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
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
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
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: 15-1314 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D Part IV Date/Time Prepared: 11/22/2023 7:41 pm

Title XVIII | Hospital | Cost

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	8,653,313	0.000000	50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0	0	0	14,131,145	0.000000	54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	11,231,200	0.000000	60.00
61.00	06100	PBP CLINICAL LAB. SERVICE-PRGM. ONLY						61.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	903,423	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	2,729,964	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	438,218	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	2,371,747	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	1,121,872	0.000000	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	254,981	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	3,491,348	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0.000000	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0.000000	75.00
75.01	03950	SLEEP DISORDER	0	0	0	1,087,335	0.000000	75.01
75.03	07501	ADULT MENTAL HEALTH	0	0	0	1,292,182	0.000000	75.03
76.97	07697	CARDIAC REHABILITATION	0	0	0	324,765	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0.000000	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0.000000	89.00
90.00	09000	CLINIC	0	0	0	0	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	14,634,697	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	322,072	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	62,988,262		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1314 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D Part IV Date/Time Prepared: 11/22/2023 7:41 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	0	0	0	0	50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0.000000	654	0	0	0	54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY	0.000000	30,743	0	0	0	60.00
61.00	06100	PBP CLINICAL LAB. SERVICE-PRGM. ONLY						61.00
65.00	06500	RESPIRATORY THERAPY	0.000000	1,625	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	7,302	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	1,754	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	10,625	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	10,202	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	51,901	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	0	0	75.00
75.01	03950	SLEEP DISORDER	0.000000	0	0	0	0	75.01
75.03	07501	ADULT MENTAL HEALTH	0.000000	0	0	0	0	75.03
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0	0	0	89.00
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	229	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		115,035	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1314 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D Part V Date/Time Prepared: 11/22/2023 7:41 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.222934	0	1,414,207	0	0	50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0.148823	0	2,880,282	0	0	54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY	0.173698	0	2,150,667	0	0	60.00
61.00	06100	PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0.000000		0	0		61.00
65.00	06500	RESPIRATORY THERAPY	0.105633	0	16,113	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.377026	0	714,737	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.370090	0	32,180	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.228311	0	902,629	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.086045	0	190,870	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.296042	0	75,239	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.306679	0	1,086,222	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	0	0	75.00
75.01	03950	SLEEP DISORDER	0.325900	0	3,328	0	0	75.01
75.03	07501	ADULT MENTAL HEALTH	0.442915	0	796,627	0	0	75.03
76.97	07697	CARDIAC REHABILITATION	0.694139	0	84,262	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC						88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER						89.00
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.247239	0	2,015,105	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	3.385591	0	101,984	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.000000		0			95.00
200.00		Subtotal (see instructions)		0	12,464,452	0	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	12,464,452	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1314 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D Part V Date/Time Prepared: 11/22/2023 7:41 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	315,275	0	50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	428,652	0	54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
60.00	06000	LABORATORY	373,567	0	60.00
61.00	06100	PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0		61.00
65.00	06500	RESPIRATORY THERAPY	1,702	0	65.00
66.00	06600	PHYSICAL THERAPY	269,474	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	11,909	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	206,080	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	16,423	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	22,274	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	333,121	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	75.00
75.01	03950	SLEEP DISORDER	1,085	0	75.01
75.03	07501	ADULT MENTAL HEALTH	352,838	0	75.03
76.97	07697	CARDIAC REHABILITATION	58,490	0	76.97
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC			88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER			89.00
90.00	09000	CLINIC	0	0	90.00
91.00	09100	EMERGENCY	498,213	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	345,276	0	92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0		95.00
200.00		Subtotal (see instructions)	3,234,379	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	3,234,379	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1314 | Component CCN: 15-Z314 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D Part V Date/Time Prepared: 11/22/2023 7:41 pm

Title XVIII | Swing Beds - SNF | 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	0.222934	0	0	0	0	50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0.148823	0	0	0	0	54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY	0.173698	0	0	0	0	60.00
61.00	06100	PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0.000000		0	0		61.00
65.00	06500	RESPIRATORY THERAPY	0.105633	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.377026	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.370090	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.228311	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.086045	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.296042	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.306679	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	0	0	75.00
75.01	03950	SLEEP DISORDER	0.325900	0	0	0	0	75.01
75.03	07501	ADULT MENTAL HEALTH	0.442915	0	0	0	0	75.03
76.97	07697	CARDIAC REHABILITATION	0.694139	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC						88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER						89.00
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.247239	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	3.385591	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.000000		0			95.00
200.00		Subtotal (see instructions)		0	0	0	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	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1314 | Component CCN: 15-Z314 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D Part V Date/Time Prepared: 11/22/2023 7:41 pm

Title XVIII | Swing Beds - SNF | 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	0	0		50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0	0		54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
60.00	06000	LABORATORY	0	0		60.00
61.00	06100	PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0			61.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0		75.00
75.01	03950	SLEEP DISORDER	0	0		75.01
75.03	07501	ADULT MENTAL HEALTH	0	0		75.03
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
	OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC				88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER				89.00
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
	OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	0		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 15-1314 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D Part I Date/Time Prepared: 11/22/2023 7:41 pm

Title XIX | Hospital | Cost

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	216,081	27,568	188,513	358	526.57	30.00
200.00	Total (lines 30 through 199)	216,081		188,513	358		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
		6.00	7.00				
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	2	1,053				30.00
200.00	Total (lines 30 through 199)	2	1,053				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-1314 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D Part II Date/Time Prepared: 11/22/2023 7:41 pm

Title XIX | 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	217,715	8,653,313	0.025160	0	0	50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	225,274	14,131,145	0.015942	3,211	51	54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0	0	58.00
60.00	06000	LABORATORY	47,845	11,231,200	0.004260	8,869	38	60.00
61.00	06100	PBP CLINICAL LAB. SERVICE-PRGM. ONLY						61.00
65.00	06500	RESPIRATORY THERAPY	12,974	903,423	0.014361	366	5	65.00
66.00	06600	PHYSICAL THERAPY	36,434	2,729,964	0.013346	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	5,876	438,218	0.013409	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	56,475	2,371,747	0.023812	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,670	1,121,872	0.001489	116	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	1,304	254,981	0.005114	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	68,125	3,491,348	0.019513	6,118	119	73.00
74.00	07400	RENAL DIALYSIS	0	0	0.000000	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0.000000	0	0	75.00
75.01	03950	SLEEP DISORDER	28,698	1,087,335	0.026393	0	0	75.01
75.03	07501	ADULT MENTAL HEALTH	27,315	1,292,182	0.021139	0	0	75.03
76.97	07697	CARDIAC REHABILITATION	10,419	324,765	0.032082	0	0	76.97
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
91.00	09100	EMERGENCY	134,491	14,634,697	0.009190	7,155	66	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	100,049	322,072	0.310642	2,358	732	92.00
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	974,664	62,988,262		28,193	1,011	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1314 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D Part III Date/Time Prepared: 11/22/2023 7:41 pm

Title XIX | Hospital | Cost

		Cost Center Description	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
			1A	1.00	2A	2.00	3.00	
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
200.00		Total (lines 30 through 199)	0	0	0	0	0	200.00

		Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
			4.00	5.00	6.00	7.00	8.00	
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	0	358	0.00	2	30.00
200.00		Total (lines 30 through 199)		0	358		2	200.00

		Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
			9.00	
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	0	30.00
200.00		Total (lines 30 through 199)	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1314 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D Part IV Date/Time Prepared: 11/22/2023 7:41 pm

Title XIX | 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
54.00	05400	RADIOLOGY - DIAGNOSTIC	0	0	0	0	0	54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
61.00	06100	PBP CLINICAL LAB. SERVICE-PRGM. ONLY						61.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	03950	SLEEP DISORDER	0	0	0	0	0	75.01
75.03	07501	ADULT MENTAL HEALTH	0	0	0	0	0	75.03
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
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
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
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: 15-1314 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D Part IV Date/Time Prepared: 11/22/2023 7:41 pm

Title XIX | 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	8,653,313	0.000000	50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0	0	0	14,131,145	0.000000	54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	11,231,200	0.000000	60.00
61.00	06100	PBP CLINICAL LAB. SERVICE-PRGM. ONLY						61.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	903,423	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	2,729,964	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	438,218	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	2,371,747	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	1,121,872	0.000000	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	254,981	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	3,491,348	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0.000000	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0.000000	75.00
75.01	03950	SLEEP DISORDER	0	0	0	1,087,335	0.000000	75.01
75.03	07501	ADULT MENTAL HEALTH	0	0	0	1,292,182	0.000000	75.03
76.97	07697	CARDIAC REHABILITATION	0	0	0	324,765	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0.000000	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0.000000	89.00
90.00	09000	CLINIC	0	0	0	0	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	14,634,697	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	322,072	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	62,988,262		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1314 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D Part IV Date/Time Prepared: 11/22/2023 7:41 pm

Title XIX | 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	0	0	0	0	50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0.000000	3,211	0	0	0	54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY	0.000000	8,869	0	0	0	60.00
61.00	06100	PBP CLINICAL LAB. SERVICE-PRGM. ONLY						61.00
65.00	06500	RESPIRATORY THERAPY	0.000000	366	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	116	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	6,118	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	0	0	75.00
75.01	03950	SLEEP DISORDER	0.000000	0	0	0	0	75.01
75.03	07501	ADULT MENTAL HEALTH	0.000000	0	0	0	0	75.03
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0	0	0	89.00
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	7,155	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	2,358	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		28,193	0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1314 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D-1 | Date/Time Prepared: 11/22/2023 7:41 pm

Title XVIII | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	440	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	358	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)	168	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	30	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)	21	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	31	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)	55	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)	8	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	250.44	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	266.32	20.00
21.00	Total general inpatient routine service cost (see instructions)	2,355,001	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)	7,764	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)	300,451	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,054,550	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	2,054,550	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)	5,738.97	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	315,643	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)	315,643	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1314 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D-1 | Date/Time Prepared: 11/22/2023 7:41 pm

Title XVIII | Hospital | Cost

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	29,007	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)	344,650	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)	45,912	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	45,912	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)	190	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	5,738.97	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,090,404	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1314 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D-1 | Date/Time Prepared: 11/22/2023 7:41 pm

Title XVIII | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	216,081	2,355,001	0.091754	1,090,404	100,049	90.00
91.00	Nursing Program cost	0	2,355,001	0.000000	1,090,404	0	91.00
92.00	Allied health cost	0	2,355,001	0.000000	1,090,404	0	92.00
93.00	All other Medical Education	0	2,355,001	0.000000	1,090,404	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1314 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D-1 | Date/Time Prepared: 11/22/2023 7:41 pm

Title XIX | 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)	440	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	358	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)	168	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	30	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)	21	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	31	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)	2	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	250.44	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	266.32	20.00
21.00	Total general inpatient routine service cost (see instructions)	2,355,001	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)	7,764	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)	300,451	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,054,550	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	2,054,550	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)	5,738.97	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	11,478	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)	11,478	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1314 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D-1 | Date/Time Prepared: 11/22/2023 7:41 pm

Title XIX | Hospital | Cost

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	13,696	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)	25,174	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)	190	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	5,738.97	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,090,404	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1314 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D-1 | Date/Time Prepared: 11/22/2023 7:41 pm

Title XIX | 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	216,081	2,355,001	0.091754	1,090,404	100,049	90.00
91.00	Nursing Program cost	0	2,355,001	0.000000	1,090,404	0	91.00
92.00	Allied health cost	0	2,355,001	0.000000	1,090,404	0	92.00
93.00	All other Medical Education	0	2,355,001	0.000000	1,090,404	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1314 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D-3 | Date/Time Prepared: 11/22/2023 7:41 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		75,500		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.222934	0	0	50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0.148823	654	97	54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	58.00
60.00	06000	LABORATORY	0.173698	30,743	5,340	60.00
61.00	06100	PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0.000000	0	0	61.00
65.00	06500	RESPIRATORY THERAPY	0.105633	1,625	172	65.00
66.00	06600	PHYSICAL THERAPY	0.377026	7,302	2,753	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.370090	1,754	649	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.228311	10,625	2,426	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.086045	10,202	878	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.296042	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.306679	51,901	15,917	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	75.00
75.01	03950	SLEEP DISORDER	0.325900	0	0	75.01
75.03	07501	ADULT MENTAL HEALTH	0.442915	0	0	75.03
76.97	07697	CARDIAC REHABILITATION	0.694139	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
90.00	09000	CLINIC	0.000000	0	0	90.00
91.00	09100	EMERGENCY	0.247239	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	3.385591	229	775	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		115,035	29,007	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)		115,035		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1314 | Component CCN: 15-Z314 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D-3 | Date/Time Prepared: 11/22/2023 7:41 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS				30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.222934	0	0	50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0.148823	0	0	54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	58.00
60.00	06000	LABORATORY	0.173698	1,467	255	60.00
61.00	06100	PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0.000000	0	0	61.00
65.00	06500	RESPIRATORY THERAPY	0.105633	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.377026	2,456	926	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.370090	510	189	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.228311	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.086045	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.296042	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.306679	4,380	1,343	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	75.00
75.01	03950	SLEEP DISORDER	0.325900	0	0	75.01
75.03	07501	ADULT MENTAL HEALTH	0.442915	0	0	75.03
76.97	07697	CARDIAC REHABILITATION	0.694139	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
90.00	09000	CLINIC	0.000000	0	0	90.00
91.00	09100	EMERGENCY	0.247239	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	3.385591	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		8,813	2,713	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)		8,813		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1314 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D-3 | Date/Time Prepared: 11/22/2023 7:41 pm

Title XIX | 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		13,510		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.222934	0	0	50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0.148823	3,211	478	54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	58.00
60.00	06000	LABORATORY	0.173698	8,869	1,541	60.00
61.00	06100	PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0.000000	0	0	61.00
65.00	06500	RESPIRATORY THERAPY	0.105633	366	39	65.00
66.00	06600	PHYSICAL THERAPY	0.377026	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.370090	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.228311	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.086045	116	10	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.296042	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.306679	6,118	1,876	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	75.00
75.01	03950	SLEEP DISORDER	0.325900	0	0	75.01
75.03	07501	ADULT MENTAL HEALTH	0.442915	0	0	75.03
76.97	07697	CARDIAC REHABILITATION	0.694139	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0	89.00
90.00	09000	CLINIC	0.000000	0	0	90.00
91.00	09100	EMERGENCY	0.247239	7,155	1,769	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	3.385591	2,358	7,983	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		28,193	13,696	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)		28,193		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-1314 | Period: From 07/01/2022 To 06/30/2023 | Worksheet E Part B Date/Time Prepared: 11/22/2023 7:41 pm

Title XVIII | Hospital | Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	3,234,379	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)	3,234,379	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)	3,266,723	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)	52,307	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	1,981,260	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)	1,233,156	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)	1,233,156	30.00
31.00	Primary payer payments	854	31.00
32.00	Subtotal (line 30 minus line 31)	1,232,302	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)	550,005	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	357,503	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	440,108	36.00
37.00	Subtotal (see instructions)	1,589,805	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.01	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.01
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		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	1,589,805	40.00
40.01	Sequestration adjustment (see instructions)	31,796	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs		40.03
41.00	Interim payments	2,015,959	41.00
41.01	Interim payments-PARHM		41.01
42.00	Tentative settlement (for contractors use only)	0	42.00
42.01	Tentative settlement-PARHM (for contractor use only)		42.01
43.00	Balance due provider/program (see instructions)	-457,950	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	25,000	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1314	Period: From 07/01/2022 To 06/30/2023	Worksheet E Part B Date/Time Prepared: 11/22/2023 7:41 pm
	Title XVIII	Hospital	Cost

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED | Provider CCN: 15-1314 | Period: From 07/01/2022 To 06/30/2023 | Worksheet E-1 Part I | Date/Time Prepared: 11/22/2023 7:41 pm

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		259,061		1,736,359	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	02/16/2023	88,200	02/16/2023	279,600	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
3.49			0		0	3.49
	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)		88,200		279,600	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)		347,261		2,015,959	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		29,314		457,950	6.02
7.00	Total Medicare program liability (see instructions)		317,947		1,558,009	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: 15-1314 | Component CCN: 15-Z314 | Period: From 07/01/2022 To 06/30/2023 | Worksheet E-1 Part I | Date/Time Prepared: 11/22/2023 7:41 pm

Title XVIII | Swing Beds - SNF | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		33,444		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	02/16/2023	38,000		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
3.49			0		0	3.49
	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)		38,000		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)		71,444		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		23,315		0	6.02
7.00	Total Medicare program liability (see instructions)		48,129		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: 15-1314	Period: From 07/01/2022 To 06/30/2023	Worksheet E-1 Part II Date/Time Prepared: 11/22/2023 7:41 pm
	Title XVIII	Hospital	Cost

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

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS | Provider CCN: 15-1314 | Component CCN: 15-Z314 | Period: From 07/01/2022 To 06/30/2023 | Worksheet E-2 | Date/Time Prepared: 11/22/2023 7:41 pm

Title XVIII | Swing Beds - SNF | Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	46,371	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)	2,740	0	3.00
3.01	Nursing and allied health payment-PARHM (see instructions)			3.01
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days	8	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)	49,111	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	49,111	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)	49,111	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)	49,111	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)	49,111	0	19.00
19.01	Sequestration adjustment (see instructions)	982	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)	0	0	19.02
19.03	Sequestration adjustment-PARHM pass-throughs			19.03
19.25	Sequestration for non-claims based amounts (see instructions)	0	0	19.25
20.00	Interim payments	71,444	0	20.00
20.01	Interim payments-PARHM			20.01
21.00	Tentative settlement (for contractor use only)	0	0	21.00
21.01	Tentative settlement-PARHM (for contractor use only)			21.01
22.00	Balance due provider/program (line 19 minus lines 19.01, 19.02, 19.25, 20, and 21)	-23,315	0	22.00
22.01	Balance due provider/program-PARHM (see instructions)			22.01
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	23.00
	Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment			
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
	Cost Reimbursement			
201.00	Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))			201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))			202.00
203.00	Total (sum of lines 201 and 202)			203.00
204.00	Medicare swing-bed SNF discharges (see instructions)			204.00
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)			
205.00	Medicare swing-bed SNF target amount			205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)			206.00
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement			
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)			208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
	Comparision of PPS versus Cost Reimbursement			
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)			215.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1314	Period: From 07/01/2022 To 06/30/2023	Worksheet E-3 Part V Date/Time Prepared: 11/22/2023 7:41 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	344,650	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)	344,650	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	348,097	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)	348,097	19.00
20.00	Deductibles (exclude professional component)	31,604	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	316,493	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	316,493	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	12,220	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	7,943	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	7,824	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	324,436	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)	324,436	30.00
30.01	Sequestration adjustment (see instructions)	6,489	30.01
30.02	Demonstration payment adjustment amount after sequestration	0	30.02
30.03	Sequestration adjustment-PARHM		30.03
31.00	Interim payments	347,261	31.00
31.01	Interim payments-PARHM		31.01
32.00	Tentative settlement (for contractor use only)	0	32.00
32.01	Tentative settlement-PARHM (for contractor use only)		32.01
33.00	Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32)	-29,314	33.00
33.01	Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01)		33.01
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	25,000	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1314	Period: From 07/01/2022 To 06/30/2023	Worksheet E-3 Part VII Date/Time Prepared: 11/22/2023 7:41 pm
	Title XIX	Hospital	Cost

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	25,174		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant programs only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	25,174	0	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	25,174	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	13,510		8.00
9.00	Ancillary service charges	28,193	0	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	41,703	0	12.00
	CUSTOMARY CHARGES			
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	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	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	41,703	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	16,529	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	25,174	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	25,174	0	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	25,174	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	25,174	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	25,174	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	25,174	0	40.00
41.00	Interim payments	25,174	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 15-1314 | Period: From 07/01/2022 To 06/30/2023 | Worksheet G | Date/Time Prepared: 11/22/2023 7:41 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	823	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	5,842,794	0	0	0	4.00
5.00	Other receivable	610,148	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-4,026,077	0	0	0	6.00
7.00	Inventory	352,718	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	2,780,406	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	180,000	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	3,208,596	0	0	0	15.00
16.00	Accumulated depreciation	-1,334,784	0	0	0	16.00
17.00	Leasehold improvements	859,079	0	0	0	17.00
18.00	Accumulated depreciation	-859,003	0	0	0	18.00
19.00	Fixed equipment	1,878,154	0	0	0	19.00
20.00	Accumulated depreciation	-944,622	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	3,427,846	0	0	0	23.00
24.00	Accumulated depreciation	-2,461,069	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	3,954,197	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	45,718	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	45,718	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	6,780,321	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	128,519	0	0	0	37.00
38.00	Salaries, wages, and fees payable	252,250	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	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	1,977,809	0	0	0	43.00
44.00	Other current liabilities	1,929,789	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	4,288,367	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	42,374	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	42,374	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	4,330,741	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	2,449,580				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)	2,449,580	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	6,780,321	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-1314 | Period: From 07/01/2022 To 06/30/2023 | Worksheet G-1 | Date/Time Prepared: 11/22/2023 7:41 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		4,144,301		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		935,611				2.00
3.00	Total (sum of line 1 and line 2)		5,079,912		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00	Contributions/Donations/Grant Revenue	451,801		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00	Rounding	4		0		0	9.00
10.00	Total additions (sum of line 4-9)		451,805		0		10.00
11.00	Subtotal (line 3 plus line 10)		5,531,717		0		11.00
12.00	Transfer from Affiliates	2,856,236		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	Released Capital	225,901		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		3,082,137		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		2,449,580		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	Contributions/Donations/Grant Revenue		0		6.00
7.00			0		7.00
8.00			0		8.00
9.00	Rounding		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	Transfer from Affiliates		0		12.00
13.00			0		13.00
14.00			0		14.00
15.00			0		15.00
16.00	Released Capital		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: 15-1314 | Period: From 07/01/2022 To 06/30/2023 | Worksheet G-2 Parts I & II Date/Time Prepared: 11/22/2023 7:41 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	1,895,312		1,895,312	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	1,895,312		1,895,312	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	1,895,312		1,895,312	17.00
18.00	Ancillary services	571,133	46,241,623	46,812,756	18.00
19.00	Outpatient services	104,300	14,787,521	14,891,821	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	0	0	0	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	2,570,745	61,029,144	63,599,889	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		17,874,171		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)		17,874,171		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 15-1314	Period: From 07/01/2022 To 06/30/2023	Worksheet G-3 Date/Time Prepared: 11/22/2023 7:41 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	63,599,889	1.00
2.00	Less contractual allowances and discounts on patients' accounts	45,169,429	2.00
3.00	Net patient revenues (line 1 minus line 2)	18,430,460	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	17,874,171	4.00
5.00	Net income from service to patients (line 3 minus line 4)	556,289	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	6,396	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	54,319	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	32,263	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	247,143	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER (SPECIFY)	0	24.00
24.01	Other Operating Income	15,734	24.01
24.06	Unclaimed Property Exemptions	23,467	24.06
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (sum of lines 6-24)	379,322	25.00
26.00	Total (line 5 plus line 25)	935,611	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	935,611	29.00