

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: 15-0113	Period: From 01/01/2023 To 12/31/2023	Worksheet S Parts I-III Date/Time Prepared: 5/24/2024 11:54 am
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PART I - COST REPORT STATUS

Provider use only	1. <input checked="" type="checkbox"/> Electronically prepared cost report	Date: 5/24/2024	Time: 11:54 am
	2. <input type="checkbox"/> Manually prepared cost report		
	3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. <input checked="" type="checkbox"/> Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no.		
Contractor use only	5. <input checked="" type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No.	10. NPR Date: 11. Contractor's Vendor Code: 4 12. <input type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.

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

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by COMMUNITY HOSPITAL ANDERSON (15-0113) for the cost reporting period beginning 01/01/2023 and ending 12/31/2023 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

	SIGNATURE OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR	CHECKBOX	ELECTRONIC SIGNATURE STATEMENT	
	1	2		
1	Holly Millard	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	Holly Millard		2
3	Signatory Title	SVP FINANCE		3
4	Date	(Dated when report is electronic)		4

	Title V	Title XVIII		HIT	Title XIX	
		Part A	Part B			
	1.00	2.00	3.00	4.00	5.00	
PART III - SETTLEMENT SUMMARY						
1.00	HOSPITAL	0	325,026	-47,539	0	0 1.00
2.00	SUBPROVIDER - IPF	0	0	0	0	0 2.00
3.00	SUBPROVIDER - IRF	0	0	0	0	0 3.00
5.00	SWING BED - SNF	0	0	0	0	0 5.00
6.00	SWING BED - NF	0	0	0	0	0 6.00
200.00	TOTAL	0	325,026	-47,539	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: 15-0113		Period: From 01/01/2023 To 12/31/2023		Worksheet S-2 Part I Date/Time Prepared: 5/24/2024 11:54 am					
1.00		2.00		3.00		4.00					
Hospital and Hospital Health Care Complex Address:											
1.00	Street: 1515 NORTH MADISON AVE		PO Box:						1.00		
2.00	City: ANDERSON		State: IN		Zip Code: 46011		County: MADISON		2.00		
		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)				
		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		COMMUNITY HOSPITAL ANDERSON	150113	26900	1	01/01/1966	N	P	P	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										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)					01/01/2023	12/31/2023		20.00		
21.00	Type of Control (see instructions)					2			21.00		
						1.00	2.00	3.00			
Inpatient PPS Information											
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.				Y	N			22.00		
22.01	Did this hospital receive interim UCPs, including supplemental UCPs, for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)				Y	Y			22.01		
22.02	Is this a newly merged hospital that requires a final UCP to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.				N	N			22.02		
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)				N	N		Y	22.03		
22.04	Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.								22.04		
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)								22.04		
22.04	Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.								22.04		
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.				3	N			23.00		

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-0113			Period: From 01/01/2023 To 12/31/2023		Worksheet S-2 Part I Date/Time Prepared: 5/24/2024 11:54 am		
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of- State Medicaid paid days	Out-of- State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days		
		1.00	2.00	3.00	4.00	5.00	6.00		
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	1,088	106	0	6	5,164	24	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.					1		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.					1		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	Y	40.00	
						V	XVII	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	Y	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 impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter "Y" for yes; otherwise, enter "N" for no in column 2.					Y	Y		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.					Y			57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.					N			58.00

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		V	XVIII	XIX		
		1.00	2.00	3.00		
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N				59.00
		NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code		
		1.00	2.00	3.00		
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2.	N				60.00
		Y/N	IME	Direct GME	IME	Direct GME
		1.00	2.00	3.00	4.00	5.00
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00
61.01	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
62.00	ACA Provisions Affecting the Health Resources and Services Administration (HRSA) 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
63.00	Teaching Hospitals that Claim Residents in Nonprovider Settings 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

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			Unweighted FTEs Nonprovi der Site	Unweighted FTEs in Hospi tal	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	0.16	0.000000	64.00	
		Program Name	Program Code	Unweighted FTEs Nonprovi der Site	Unweighted FTEs in Hospi tal	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 Nonprovi der Site	Unweighted FTEs in Hospi tal	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	0.16	0.000000	66.00	
		Program Name	Program Code	Unweighted FTEs Nonprovi der Site	Unweighted FTEs in Hospi tal	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	67.00

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			1.00				
68.00	Direct GME in Accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-49072 (August 10, 2022) For a cost reporting period beginning prior to October 1, 2022, did you obtain permission from your MAC to apply the new DGME formula in accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-49072 (August 10, 2022)?			68.00			
			1.00	2.00	3.00		
Inpatient Psychiatric Facility PPS							
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.			N	70.00		
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			N	N	0	71.00
Inpatient Rehabilitation Facility PPS							
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.			N	75.00		
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			N	N	0	76.00
			1.00				
Long Term Care Hospital PPS							
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.			N	80.00		
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.			N	81.00		
TEFRA Providers							
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.			N	85.00		
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.			N	86.00		
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.			N	87.00		
			Approved for Permanent Adjustment (Y/N)	Number of Approved Permanent Adjustments			
			1.00	2.00			
88.00	Column 1: Is this hospital approved for a permanent adjustment to the TEFRA target amount per discharge? Enter "Y" for yes or "N" for no. If yes, complete col. 2 and line 89. (see instructions) Column 2: Enter the number of approved permanent adjustments.			N	0	88.00	
			Wkst. A Line No.	Effective Date	Approved Permanent Adjustment Amount Per Discharge		
			1.00	2.00	3.00		
89.00	Column 1: If line 88, column 1 is Y, enter the Worksheet A line number on which the per discharge permanent adjustment approval was based. Column 2: Enter the effective date (i.e., the cost reporting period beginning date) for the permanent adjustment to the TEFRA target amount per discharge. Column 3: Enter the amount of the approved permanent adjustment to the TEFRA target amount per discharge.			0.00	0	89.00	
			V	XIX			
			1.00	2.00			
Title V and XIX Services							
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.			N	Y	90.00	
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.			N	N	91.00	
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.			N	N	92.00	
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.			N	N	93.00	
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.			N	N	94.00	
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.			0.00	0.00	95.00	
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.			N	N	96.00	
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.			0.00	0.00	97.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-0113	Period: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part I Date/Time Prepared: 5/24/2024 11:54 am	
		V 1.00	XIX 2.00		
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	N	98.00	
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. 1? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.01	
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.02	
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03	
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04	
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.05	
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.06	
Rural Providers					
105.00	Does this hospital qualify as a CAH?	N		105.00	
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	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	
107.01	If this facility is a REH (line 3, column 4, is "12"), is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no. (see instructions)			107.01	
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00	
		Physical 1.00	Occupational 2.00	Speech 3.00	Respiratory 4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N
				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
112.00	Did this hospital participate in the Pennsylvania Rural Health Model (PARHM) demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.		N		112.00
Miscellaneous Cost Reporting Information					
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N			0115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.		1		118.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-0113	Period: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part I Date/Time Prepared: 5/24/2024 11:54 am
		Premiums	Losses	Insurance
		1.00	2.00	3.00
118.01	List amounts of malpractice premiums and paid losses:	1,304,603	0	0
		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.		N	118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.		N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.		Y	121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.		N	122.00
123.00	Did the facility and/or its subproviders (if applicable) purchase professional services, e.g., legal, accounting, tax preparation, bookkeeping, payroll, and/or management/consulting services, from an unrelated organization? In column 1, enter "Y" for yes or "N" for no. If column 1 is "Y", were the majority of the expenses, i.e., greater than 50% of total professional services expenses, for services purchased from unrelated organizations located in a CBSA outside of the main hospital CBSA? In column 2, enter "Y" for yes or "N" for no.		N	123.00
Certified Transplant Center Information				
125.00	Does this facility operate a Medicare-certified transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.		N	125.00
126.00	If this is a Medicare-certified kidney transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare-certified heart transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare-certified liver transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare-certified lung transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare-certified pancreas transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare-certified intestinal transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare-certified islet transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	Removed and reserved			133.00
134.00	If this is a hospital-based organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
All Providers				
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)		Y	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: COMMUNITY HEALTH NETWORK	Contractor's Name: WPS	Contractor's Number: 08101	141.00
142.00	Street: 1500 NORTH RITTER AVE	PO Box:		142.00
143.00	City: INDIANAPOLIS	State: IN	Zip Code: 46219	143.00
			1.00	
144.00	Are provider based physicians' costs included in Worksheet A?		Y	144.00
		1.00	2.00	
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.		Y	145.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.		N	146.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-0113		Period: From 01/01/2023 To 12/31/2023		Worksheet S-2 Part I Date/Time Prepared: 5/24/2024 11:54 am		
1.00								
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.						N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.						N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.						N	149.00
		Part A	Part B	Title V	Title XIX			
		1.00	2.00	3.00	4.00			
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)								
155.00	Hospital	N	N	N	N	N	155.00	
156.00	Subprovider - IPF	N	N	N	N	N	156.00	
157.00	Subprovider - IRF	N	N	N	N	N	157.00	
158.00	SUBPROVIDER						158.00	
159.00	SNF	N	N	N	N	N	159.00	
160.00	HOME HEALTH AGENCY	N	N	N	N	N	160.00	
161.00	CMHC		N	N	N	N	161.00	
1.00								
Multi campus								
165.00	Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.						N	165.00
		Name	County	State	Zip Code	CBSA	FTE/Campus	
		0	1.00	2.00	3.00	4.00	5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00	166.00
1.00								
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act								
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.						Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)							168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)							168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)						9.99	169.00
		Beginning	Ending					
		1.00	2.00					
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)							170.00
		1.00	2.00					
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. 1, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)						N	0171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 15-0113		Period: From 01/01/2023 To 12/31/2023		Worksheet S-2 Part II Date/Time Prepared: 5/24/2024 11:54 am	
				Y/N	Date		
				1.00	2.00		
PART II - HOSPITAL AND HOSPITAL HEALTHCARE COMPLEX REIMBURSEMENT QUESTIONNAIRE							
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.							
COMPLETED BY ALL HOSPITALS							
Provider Organization and Operation							
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N					1.00
				Y/N	Date		V/I
				1.00	2.00		3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N					2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N					3.00
				Y/N	Type	Date	
				1.00	2.00	3.00	
Financial Data and Reports							
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	03/28/2024			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.			Y			15.00
				Part A		Part B	
				Y/N	Date	Y/N	Date
				1.00	2.00	3.00	4.00
PS&R Data							
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		N			16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	04/11/2024	Y	04/11/2024		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N			18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N			19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 15-0113		Period: From 01/01/2023 To 12/31/2023		Worksheet S-2 Part II Date/Time Prepared: 5/24/2024 11:54 am	
		Description		Y/N	Y/N		
		0		1.00	3.00		
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N		20.00
		Y/N	Date	Y/N	Date		
		1.00	2.00	3.00	4.00		
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.			N	N		21.00
						1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)							
Capital Related Cost							
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions				N		22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				N		23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				N		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				N		25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				N		26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				N		27.00
Interest Expense							
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				N		28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				N		29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				N		30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				N		31.00
Purchased Services							
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				N		32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				N		33.00
Provider-Based Physicians							
34.00	Were services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				N		34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				N		35.00
				Y/N	Date		
				1.00	2.00		
Home Office Costs							
36.00	Were home office costs claimed on the cost report?				N		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.				N		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.	SHIRLEY		BI SHOP			41.00
42.00	Enter the employer/company name of the cost report preparer.	COMMUNITY HEALTH NETWORK					42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-355-4135		SBI SHOP@ECOMMUNITY.COM			43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 15-0113	Period: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part II Date/Time Prepared: 5/24/2024 11:54 am
		3.00		
Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	NETWORK DIRECTOR OF 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: 15-0113

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

Worksheet S-3
Part I
Date/Time Prepared:
5/24/2024 11:54 am

Component	Worksheet A	No. of Beds	Bed Days Available	CAH/REH Hours	I/P Days / O/P		
	Line No.				Visits	Trips	
	1.00	2.00	3.00	4.00	5.00		
PART I - STATISTICAL DATA							
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	100	37,149	0.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		100	37,149	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	17	6,205	0.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		117	43,354	0.00	0	14.00
15.00	CAH visits					0	15.00
15.10	REH hours and visits				0.00	0	15.10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		117				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: 15-0113

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

Worksheet S-3
Part I
Date/Time Prepared:
5/24/2024 11:54 am

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVII I	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
	6.00	7.00	8.00	9.00	10.00	
PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	4,710	677	19,164		1.00
2.00	HMO and other (see instructions)	8,425	4,640			2.00
3.00	HMO IPF Subprovider	0	0			3.00
4.00	HMO IRF Subprovider	0	0			4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0		5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0		6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	4,710	677	19,164		7.00
8.00	INTENSIVE CARE UNIT	1,168	320	4,135		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		727	921		13.00
14.00	Total (see instructions)	5,878	1,724	24,220	0.16	872.69
15.00	CAH visits	0	0	0		15.00
15.10	REH hours and visits	0	0	0		15.10
16.00	SUBPROVIDER - IPF					16.00
17.00	SUBPROVIDER - IRF					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)			54		24.10
25.00	CMHC - CMHC					25.00
26.00	RURAL HEALTH CLINIC					26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00
27.00	Total (sum of lines 14-26)				0.16	872.69
28.00	Observation Bed Days		382	2,011		28.00
29.00	Ambulance Trips	0				29.00
30.00	Employee discount days (see instruction)			153		30.00
31.00	Employee discount days - IRF			0		31.00
32.00	Labor & delivery days (see instructions)	0	24	260		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: 15-0113

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

Worksheet S-3
Part I
Date/Time Prepared:
5/24/2024 11:54 am

Component	Full Time Equivalents	Discharges			Total All Patients		
		Nonpaid Workers	Title V	Title XVIII			Title XIX
		11.00	12.00	13.00			14.00
PART I - STATISTICAL DATA							
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	1,325	203	6,217	1.00
2.00	HMO and other (see instructions)			1,759	1,190		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	1,325	203	6,217	14.00
15.00	CAH visits						15.00
15.10	REH hours and visits						15.10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care						34.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 15-0113

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

Worksheet S-3
Part II
Date/Time Prepared:
5/24/2024 11:54 am

	Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART II - WAGE DATA							
SALARIES							
1.00	Total salaries (see instructions)	200.00	71,820,063	-375,015	71,445,048	1,815,197.00	39.36
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00
4.00	Physician-Part A - Administrative		124,189	0	124,189	832.00	149.27
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00
5.00	Physician and Non-Physician-Part B		572,609	0	572,609	9,485.00	60.37
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00
9.00	SNF	44.00	0	0	0	0.00	0.00
10.00	Excluded area salaries (see instructions)		726,679	-860	725,819	19,062.00	38.08
OTHER WAGES & RELATED COSTS							
11.00	Contract Labor: Direct Patient Care		2,100,925	0	2,100,925	16,333.00	128.63
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00
13.00	Contract Labor: Physician-Part A - Administrative		390,438	0	390,438	3,221.00	121.22
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00
14.01	Home office salaries		12,569,597	0	12,569,597	287,132.00	43.78
14.02	Related organization salaries		0	0	0	0.00	0.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00
16.01	Home office Physicians Part A - Teaching		0	0	0	0.00	0.00
16.02	Home office contract Physicians Part A - Teaching		0	0	0	0.00	0.00
WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		18,835,729	0	18,835,729		
18.00	Wage-related costs (other) (see instructions)						
19.00	Excluded areas		199,458	0	199,458		
20.00	Non-physician anesthetist Part A		0	0	0		
21.00	Non-physician anesthetist Part B		0	0	0		
22.00	Physician Part A - Administrative		11,100	0	11,100		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		114,871	0	114,871		
24.00	Wage-related costs (RHC/FQHC)		0	0	0		
25.00	Interns & residents (in an approved program)		0	0	0		
25.50	Home office wage-related (core)		3,557,537	0	3,557,537		
25.51	Related organization wage-related (core)		0	0	0		
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0		

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 15-0113

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

Worksheet S-3
Part II
Date/Time Prepared:
5/24/2024 11:54 am

	Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
25.53	Home office: Physicians Part A - Teaching - wage-related (core)	0	0	0			25.53
OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	50,116	0	50,116	1,852.00	27.06	26.00
27.00	Administrative & General	7,336,474	-98,120	7,238,354	190,983.00	37.90	27.00
28.00	Administrative & General under contract (see inst.)	2,964,144	0	2,964,144	21,921.00	135.22	28.00
29.00	Maintenance & Repairs	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	1,886,221	-6,523	1,879,698	50,278.00	37.39	30.00
31.00	Laundry & Linen Service	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	2,199,522	0	2,199,522	96,066.00	22.90	32.00
33.00	Housekeeping under contract (see instructions)	0	0	0	0.00	0.00	33.00
34.00	Dietary	1,769,683	-1,211,144	558,539	24,010.00	23.26	34.00
35.00	Dietary under contract (see instructions)	0	0	0	0.00	0.00	35.00
36.00	Cafeteria	44,574	1,195,801	1,240,375	53,453.00	23.20	36.00
37.00	Maintenance of Personnel	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	1,719,710	-119	1,719,591	51,588.00	33.33	38.00
39.00	Central Services and Supply	446,901	-1,567	445,334	17,502.00	25.44	39.00
40.00	Pharmacy	2,948,188	-3,692	2,944,496	59,308.00	49.65	40.00
41.00	Medical Records & Medical Records Library	0	0	0	0.00	0.00	41.00
42.00	Social Service	0	0	0	0.00	0.00	42.00
43.00	Other General Service	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 15-0113

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

Worksheet S-3
Part III
Date/Time Prepared:
5/24/2024 11:54 am

	Worksheet A Line Number	Amount Reported	Recl assi fi cati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	74,211,598	-375,015	73,836,583	1,827,633.00	40.40	1.00
2.00	Excluded area salaries (see instructions)	726,679	-860	725,819	19,062.00	38.08	2.00
3.00	Subtotal salaries (line 1 minus line 2)	73,484,919	-374,155	73,110,764	1,808,571.00	40.42	3.00
4.00	Subtotal other wages & related costs (see inst.)	15,060,960	0	15,060,960	306,686.00	49.11	4.00
5.00	Subtotal wage-related costs (see inst.)	22,404,366	0	22,404,366	0.00	30.64	5.00
6.00	Total (sum of lines 3 thru 5)	110,950,245	-374,155	110,576,090	2,115,257.00	52.28	6.00
7.00	Total overhead cost (see instructions)	21,365,533	-125,364	21,240,169	566,961.00	37.46	7.00

HOSPITAL WAGE RELATED COSTS	Provider CCN: 15-0113	Period: From 01/01/2023 To 12/31/2023	Worksheet S-3 Part IV Date/Time Prepared: 5/24/2024 11:54 am
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		Amount Reported	
		1.00	
PART IV - WAGE RELATED COSTS			
Part A - Core List			
RETIREMENT COST			
1.00	401K Employer Contributions	2,893,338	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)			
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
HEALTH AND INSURANCE COST			
8.00	Health Insurance (Purchased or Self Funded)	0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	7,860,959	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	1,949,092	9.00
10.00	Dental, Hearing and Vision Plan	66,920	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	33,114	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	875,902	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	256,993	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Noncumulative portion)	0	16.00
TAXES			
17.00	FICA-Employers Portion Only	5,274,347	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	-51,508	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
OTHER			
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	2,000	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	19,161,157	24.00
Part B - Other than Core Related Cost			
25.00	OTHER WAGE RELATED COSTS (SPECIFY)		25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST		Provider CCN: 15-0113	Period: From 01/01/2023 To 12/31/2023	Worksheet S-3 Part V Date/Time Prepared: 5/24/2024 11:54 am
Cost Center Description		Contract Labor	Benefit Cost	
		1.00	2.00	
PART V - Contract Labor and Benefit Cost				
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost	2,100,925	19,161,157	1.00
2.00	Hospital	2,100,925	18,961,699	2.00
3.00	SUBPROVIDER - IPF			3.00
4.00	SUBPROVIDER - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	SKILLED NURSING FACILITY			8.00
9.00	NURSING FACILITY			9.00
10.00	OTHER LONG TERM CARE I			10.00
11.00	Hospital-Based HHA			11.00
12.00	AMBULATORY SURGICAL CENTER (D.P.) I			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	RENAL DIALYSIS I	0	0	17.00
18.00	Other	0	199,458	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 15-0113	Period: From 01/01/2023 To 12/31/2023	Worksheet S-10 Parts I & II Date/Time Prepared: 5/24/2024 11:54 am
				1.00
PART I - HOSPITAL AND HOSPITAL COMPLEX DATA				
Uncompensated and Indigent Care Cost-to-Charge Ratio				
1.00	Cost to charge ratio (see instructions)		0.204216	1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid		47,766,293	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?		N	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid		-3,024,697	5.00
6.00	Medicaid charges		188,824,918	6.00
7.00	Medicaid cost (line 1 times line 6)		38,561,069	7.00
8.00	Difference between net revenue and costs for Medicaid program (see instructions)		0	8.00
Children's Health Insurance Program (CHIP) (see instructions for each line)				
9.00	Net revenue from stand-alone CHIP		0	9.00
10.00	Stand-alone CHIP charges		0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)		0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (see instructions)		0	12.00
Other state or local government indigent care program (see instructions for each line)				
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)		0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)		0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (see instructions)		0	16.00
Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)				
17.00	Private grants, donations, or endowment income restricted to funding charity care		0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations		21,284	18.00
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		0	19.00
		Uninsured patients	Insured patients	Total (col. 1 + col. 2)
		1.00	2.00	3.00
Uncompensated care cost (see instructions for each line)				
20.00	Charity care charges and uninsured discounts (see instructions)	3,811,570	1,826,443	5,638,013
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	778,384	1,539,239	2,317,623
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0
23.00	Cost of charity care (see instructions)	778,384	1,539,239	2,317,623
				1.00
24.00	Does the amount on line 20 col. 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit		0	25.00
25.01	Charges for insured patients' liability (see instructions)		360,907	25.01
26.00	Bad debt amount (see instructions)		9,106,198	26.00
27.00	Medicare reimbursable bad debts (see instructions)		95,129	27.00
27.01	Medicare allowable bad debts (see instructions)		146,353	27.01
28.00	Non-Medicare bad debt amount (see instructions)		8,959,845	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)		1,880,968	29.00
30.00	Cost of uncompensated care (line 23, col. 3, plus line 29)		4,198,591	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		4,198,591	31.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 15-0113	Period: From 01/01/2023 To 12/31/2023	Worksheet S-10 Parts I & II Date/Time Prepared: 5/24/2024 11:54 am
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				1.00	
PART II - HOSPITAL DATA					
Uncompensated and Indigent Care Cost-to-Charge Ratio					
1.00	Cost to charge ratio (see instructions)			0.204216	1.00
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid				2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?				3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?				4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid				5.00
6.00	Medicaid charges				6.00
7.00	Medicaid cost (line 1 times line 6)				7.00
8.00	Difference between net revenue and costs for Medicaid program (see instructions)				8.00
Children's Health Insurance Program (CHIP) (see instructions for each line)					
9.00	Net revenue from stand-alone CHIP				9.00
10.00	Stand-alone CHIP charges				10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)				11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (see instructions)				12.00
Other state or local government indigent care program (see instructions for each line)					
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)				13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)				14.00
15.00	State or local indigent care program cost (line 1 times line 14)				15.00
16.00	Difference between net revenue and costs for state or local indigent care program (see instructions)				16.00
Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)					
17.00	Private grants, donations, or endowment income restricted to funding charity care				17.00
18.00	Government grants, appropriations or transfers for support of hospital operations				18.00
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)				19.00
		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
Uncompensated care cost (see instructions for each line)					
20.00	Charity care charges and uninsured discounts (see instructions)	3,811,570	1,826,443	5,638,013	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	778,384	1,539,239	2,317,623	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 (see instructions)	778,384	1,539,239	2,317,623	23.00
				1.00	
24.00	Does the amount on line 20 col. 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?			N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit			0	25.00
25.01	Charges for insured patients' liability (see instructions)			360,907	25.01
26.00	Bad debt amount (see instructions)			9,106,198	26.00
27.00	Medicare reimbursable bad debts (see instructions)			95,129	27.00
27.01	Medicare allowable bad debts (see instructions)			146,353	27.01
28.00	Non-Medicare bad debt amount (see instructions)			8,959,845	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)			1,880,968	29.00
30.00	Cost of uncompensated care (line 23, col. 3, plus line 29)			4,198,591	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			4,198,591	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES			Provider CCN: 15-0113		Period: From 01/01/2023 To 12/31/2023		Worksheet A	
Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassified (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		0	0	2,919,868	2,919,868	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	6,263,909	6,263,909	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	50,116	30,019	80,135	-720	79,415	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	7,336,474	74,978,166	82,314,640	-755,950	81,558,690	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	1,886,221	4,889,243	6,775,464	-1,262,021	5,513,443	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	553,108	553,108	-553,108	0	8.00
9.00	00900	HOUSEKEEPING	2,199,522	1,145,271	3,344,793	76,946	3,421,739	9.00
10.00	01000	DIETARY	1,769,683	1,879,515	3,649,198	-2,571,921	1,077,277	10.00
11.00	01100	CAFETERIA	44,574	64,467	109,041	2,331,466	2,440,507	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	1,719,710	614,876	2,334,586	-128,914	2,205,672	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	446,901	242,638	689,539	-109,653	579,886	14.00
15.00	01500	PHARMACY	2,948,188	8,494,339	11,442,527	-7,522,658	3,919,869	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	20,777	20,777	0	20,777	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING PROGRAM	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(EMS)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	15,643,395	7,189,124	22,832,519	-3,436,156	19,396,363	30.00
31.00	03100	INTENSIVE CARE UNIT	4,716,495	1,913,154	6,629,649	-438,209	6,191,440	31.00
43.00	04300	NURSERY	0	0	0	1,552,121	1,552,121	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	8,092,489	23,891,362	31,983,851	-14,641,970	17,341,881	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	1,423,344	1,423,344	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,974,857	1,395,757	3,370,614	-703,446	2,667,168	54.00
54.01	05401	ULTRASOUND	602,907	224,646	827,553	28,209	855,762	54.01
56.00	05600	RADIOISOTOPE	339,123	462,960	802,083	-262,527	539,556	56.00
57.00	05700	CT SCAN	757,208	861,905	1,619,113	-65,759	1,553,354	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	622,192	1,323,311	1,945,503	-468,932	1,476,571	58.00
59.00	05900	CARDIAC CATHETERIZATION	808,168	1,819,525	2,627,693	-1,347,461	1,280,232	59.00
60.00	06000	LABORATORY	2,618,636	5,326,445	7,945,081	-282,581	7,662,500	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	218,188	628,354	846,542	-2,947	843,595	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	2,246,486	877,028	3,123,514	-175,918	2,947,596	65.00
66.00	06600	PHYSICAL THERAPY	3,332,999	1,965,430	5,298,429	-1,632,468	3,665,961	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	506,798	506,798	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	259,353	259,353	68.00
69.00	06900	ELECTROCARDIOLOGY	1,203,785	544,224	1,748,009	-132,030	1,615,979	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	587,756	437,269	1,025,025	-25,982	999,043	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	7,375,798	7,375,798	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	8,734,562	8,734,562	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,017	3,017	7,585,501	7,588,518	73.00
74.00	07400	RENAL DIALYSIS	0	434,270	434,270	-7,409	426,861	74.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND/OSTOMY CLINIC	674,178	1,414,271	2,088,449	-192,383	1,896,066	90.01
90.02	09002	CTR ADVANCED HEART CARE	374,161	132,061	506,222	77	506,299	90.02
90.03	09003	RADIATION ONCOLOGY	1,945,135	3,067,786	5,012,921	-912,840	4,100,081	90.03
90.04	09004	DIABETIC PLUS CLINIC	395,909	99,301	495,210	-2,105	493,105	90.04
90.05	09005	ANTI COAGULATION CLINIC	355,317	110,224	465,541	0	465,541	90.05
90.06	09006	MAB 3611 REED	0	2,086	2,086	-2,086	0	90.06
91.00	09100	EMERGENCY	5,182,611	2,199,958	7,382,569	-179,120	7,203,449	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	71,093,384	149,235,887	220,329,271	1,240,678	221,569,949	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	WELLNESS CENTERS	617,062	551,791	1,168,853	-380,046	788,807	190.01
190.02	19002	MONTI CELLO HSE.	0	51,807	51,807	-31,875	19,932	190.02
190.03	19003	ROCK STEADY BOXING	109,617	64,762	174,379	-22,874	151,505	190.03
190.04	19004	DIABETES MD	0	136	136	0	136	190.04

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES			Provider CCN: 15-0113		Period: From 01/01/2023 To 12/31/2023		Worksheet A Date/Time Prepared: 5/24/2024 11:54 am	
Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)	
			1.00	2.00	3.00	4.00	5.00	
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	2,305,889	2,305,889	-778,340	1,527,549	192.00
192.01	19201	MUNCIE MD OFFICES	0	37,697	37,697	-23,828	13,869	192.01
192.02	19202	RESIDENTIAL PROPERTY (1430 N MADISON	0	6,227	6,227	-3,715	2,512	192.02
200.00		TOTAL (SUM OF LINES 118 through 199)	71,820,063	152,254,196	224,074,259	0	224,074,259	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 15-0113

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

Worksheet A
Date/Time Prepared:
5/24/2024 11:54 am

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	0	2,919,868	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	4,114,065	10,377,974	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,615,966	2,695,381	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-50,962,887	30,595,803	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	6.00
7.00	00700	OPERATION OF PLANT	0	5,513,443	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	8.00
9.00	00900	HOUSEKEEPING	0	3,421,739	9.00
10.00	01000	DIETARY	0	1,077,277	10.00
11.00	01100	CAFETERIA	-1,115,811	1,324,696	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	1,516,689	3,722,361	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	472,494	1,052,380	14.00
15.00	01500	PHARMACY	0	3,919,869	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,068,520	1,089,297	16.00
17.00	01700	SOCIAL SERVICE	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	19.00
20.00	02000	NURSING PROGRAM	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	14,234	14,234	21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	33,648	33,648	22.00
23.00	02300	PARAMED ED PRGM-(EMS)	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-668,419	18,727,944	30.00
31.00	03100	INTENSIVE CARE UNIT	-761	6,190,679	31.00
43.00	04300	NURSERY	0	1,552,121	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-3,524,739	13,817,142	50.00
51.00	05100	RECOVERY ROOM	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,423,344	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	101,959	2,769,127	54.00
54.01	05401	ULTRASOUND	0	855,762	54.01
56.00	05600	RADIOISOTOPE	0	539,556	56.00
57.00	05700	CT SCAN	0	1,553,354	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	1,476,571	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	1,280,232	59.00
60.00	06000	LABORATORY	-1,620	7,660,880	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	843,595	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	-3,260	2,944,336	65.00
66.00	06600	PHYSICAL THERAPY	-61	3,665,900	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	506,798	67.00
68.00	06800	SPEECH PATHOLOGY	0	259,353	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,615,979	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	999,043	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	7,375,798	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	8,734,562	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	7,588,518	73.00
74.00	07400	RENAL DIALYSIS	0	426,861	74.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	78.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	90.00
90.01	09001	WOUND/OSTOMY CLINIC	0	1,896,066	90.01
90.02	09002	CTR ADVANCED HEART CARE	-311,809	194,490	90.02
90.03	09003	RADIATION ONCOLOGY	-574,624	3,525,457	90.03
90.04	09004	DIABETIC PLUS CLINIC	0	493,105	90.04
90.05	09005	ANTI COAGULATION CLINIC	0	465,541	90.05
90.06	09006	MAB 3611 REED	0	0	90.06
91.00	09100	EMERGENCY	154,445	7,357,894	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	102.00
SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-47,071,971	174,497,978	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
190.01	19001	WELLNESS CENTERS	0	788,807	190.01
190.02	19002	MONTICELLO HSE.	0	19,932	190.02
190.03	19003	ROCK STEADY BOXING	0	151,505	190.03
190.04	19004	DIABETES MD	0	136	190.04
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	1,527,549	192.00
192.01	19201	MUNCIE MD OFFICES	0	13,869	192.01

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES		Provider CCN: 15-0113		Period: From 01/01/2023 To 12/31/2023	Worksheet A Date/Time Prepared: 5/24/2024 11:54 am
Cost Center Description		Adjustments (See A-8)	Net Expenses For Allocation		
192.02	19202 RESIDENTIAL PROPERTY (1430 N MADISON	6.00	7.00		
200.00	200.00 TOTAL (SUM OF LINES 118 through 199)	0	2,512		192.02
		-47,071,971	177,002,288		200.00

RECLASSIFICATIONS

Provider CCN: 15-0113

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

Worksheet A-6

Date/Time Prepared:
5/24/2024 11:54 am

		Increases				
Cost Center		Line #	Salary	Other		
2.00	3.00	4.00	5.00			
A - Chargeable Medical Supplies						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	0	1.00	
2.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	7,375,798	2.00	
3.00	HOUSEKEEPING	9.00	0	0	3.00	
4.00	DIETARY	10.00	0	0	4.00	
5.00	NURSING ADMINISTRATION	13.00	0	0	5.00	
6.00	CENTRAL SERVICES & SUPPLY	14.00	0	0	6.00	
7.00	PHARMACY	15.00	0	0	7.00	
8.00	ADULTS & PEDIATRICS	30.00	0	0	8.00	
9.00	INTENSIVE CARE UNIT	31.00	0	0	9.00	
10.00	OPERATING ROOM	50.00	0	0	10.00	
11.00	RADIOLOGY-DIAGNOSTIC	54.00	0	0	11.00	
12.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	0	12.00	
13.00	CARDIAC CATHETERIZATION	59.00	0	0	13.00	
14.00	LABORATORY	60.00	0	0	14.00	
15.00	RESPIRATORY THERAPY	65.00	0	0	15.00	
16.00	PHYSICAL THERAPY	66.00	0	0	16.00	
17.00	ELECTROCARDIOLOGY	69.00	0	0	17.00	
18.00	ELECTROENCEPHALOGRAPHY	70.00	0	0	18.00	
19.00	RADIATION ONCOLOGY	90.03	0	0	19.00	
20.00	EMERGENCY	91.00	0	0	20.00	
21.00	WELLNESS CENTERS	190.01	0	0	21.00	
22.00		0.00	0	0	22.00	
23.00		0.00	0	0	23.00	
24.00		0.00	0	0	24.00	
25.00		0.00	0	0	25.00	
TOTALS			0	7,375,798		
B - Implantable Device Reclass						
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	8,734,562	1.00	
2.00		0.00	0	0	2.00	
3.00		0.00	0	0	3.00	
TOTALS			0	8,734,562		
C - Drugs Charges to Pat						
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	7,585,501	1.00	
2.00		0.00	0	0	2.00	
3.00		0.00	0	0	3.00	
4.00		0.00	0	0	4.00	
5.00		0.00	0	0	5.00	
6.00		0.00	0	0	6.00	
7.00		0.00	0	0	7.00	
8.00		0.00	0	0	8.00	
9.00		0.00	0	0	9.00	
10.00		0.00	0	0	10.00	
11.00		0.00	0	0	11.00	
12.00		0.00	0	0	12.00	
13.00		0.00	0	0	13.00	
14.00		0.00	0	0	14.00	
15.00		0.00	0	0	15.00	
16.00		0.00	0	0	16.00	
17.00		0.00	0	0	17.00	
18.00		0.00	0	0	18.00	
19.00		0.00	0	0	19.00	
20.00		0.00	0	0	20.00	
21.00		0.00	0	0	21.00	
22.00		0.00	0	0	22.00	
TOTALS			0	7,585,501		
D - Depreciation Expense						
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	6,770,795	1.00	
2.00		0.00	0	0	2.00	
3.00		0.00	0	0	3.00	
4.00		0.00	0	0	4.00	
5.00		0.00	0	0	5.00	
6.00		0.00	0	0	6.00	
7.00		0.00	0	0	7.00	
8.00		0.00	0	0	8.00	
9.00		0.00	0	0	9.00	
10.00		0.00	0	0	10.00	
11.00		0.00	0	0	11.00	
12.00		0.00	0	0	12.00	
13.00		0.00	0	0	13.00	
14.00		0.00	0	0	14.00	

RECLASSIFICATIONS

Provider CCN: 15-0113

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

Worksheet A-6

Date/Time Prepared:
5/24/2024 11:54 am

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
18.00		0.00	0	0		18.00
19.00		0.00	0	0		19.00
20.00		0.00	0	0		20.00
21.00		0.00	0	0		21.00
22.00		0.00	0	0		22.00
23.00		0.00	0	0		23.00
24.00		0.00	0	0		24.00
25.00		0.00	0	0		25.00
26.00		0.00	0	0		26.00
27.00		0.00	0	0		27.00
28.00		0.00	0	0		28.00
29.00		0.00	0	0		29.00
30.00		0.00	0	0		30.00
31.00		0.00	0	0		31.00
32.00		0.00	0	0		32.00
33.00		0.00	0	0		33.00
34.00		0.00	0	0		34.00
35.00		0.00	0	0		35.00
TOTALS			0	6,770,795		
F - Other Capital Rental						
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	2,267,192		1.00
2.00	CENTRAL SERVICES & SUPPLY	14.00	0	67		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
18.00		0.00	0	0		18.00
TOTALS			0	2,267,259		
G - STD BENEFIT RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	98,120		1.00
2.00	OPERATION OF PLANT	7.00	0	6,523		2.00
3.00	OCCUPATIONAL THERAPY	67.00	0	21,953		3.00
4.00	SPEECH PATHOLOGY	68.00	0	15,343		4.00
5.00	NURSING ADMINISTRATION	13.00	0	119		5.00
6.00	CENTRAL SERVICES & SUPPLY	14.00	0	1,567		6.00
7.00	PHARMACY	15.00	0	3,692		7.00
8.00	ADULTS & PEDIATRICS	30.00	0	75,508		8.00
9.00	INTENSIVE CARE UNIT	31.00	0	20,367		9.00
10.00	OPERATING ROOM	50.00	0	62,301		10.00
11.00	RADIOLOGY-DIAGNOSTIC	54.00	0	4,069		11.00
12.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	1,705		12.00
13.00	CARDIAC CATHETERIZATION	59.00	0	101		13.00
14.00	LABORATORY	60.00	0	7,557		14.00
15.00	RESPIRATORY THERAPY	65.00	0	8,288		15.00
16.00	PHYSICAL THERAPY	66.00	0	24,195		16.00
17.00	ELECTROCARDIOLOGY	69.00	0	12,899		17.00
18.00	ELECTROENCEPHALOGRAPHY	70.00	0	4,181		18.00
19.00	RADIATION ONCOLOGY	90.03	0	3,648		19.00
20.00	EMERGENCY	91.00	0	2,019		20.00
21.00	WELLNESS CENTERS	190.01	0	860		21.00
TOTALS			0	375,015		
H - Therapy Recl ass						
1.00	OCCUPATIONAL THERAPY	67.00	373,436	0		1.00
2.00	SPEECH PATHOLOGY	68.00	187,941	0		2.00
3.00	OCCUPATIONAL THERAPY	67.00	0	111,409		3.00
4.00	SPEECH PATHOLOGY	68.00	0	56,069		4.00
TOTALS			561,377	167,478		

RECLASSIFICATIONS

Provider CCN: 15-0113

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

Worksheet A-6

Date/Time Prepared:
5/24/2024 11:54 am

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
I - Labor and Delivery					
1.00	NURSERY	43.00	907,295	0	1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	832,018	0	2.00
3.00	NURSERY	43.00	0	644,826	3.00
4.00	DELIVERY ROOM & LABOR ROOM	52.00	0	591,326	4.00
	TOTALS		1,739,313	1,236,152	
J - Cafeteria					
1.00	CAFETERIA	11.00	1,195,801	0	1.00
2.00	CAFETERIA	11.00	0	1,135,665	2.00
	TOTALS		1,195,801	1,135,665	
K - Building Depreciation					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	2,774,078	1.00
	TOTALS		0	2,774,078	
L - Capital Insurance Costs					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	145,790	1.00
	TOTALS		0	145,790	
M - Radiology Support Staff					
1.00	ULTRASOUND	54.01	34,684	0	1.00
2.00	RADIOISOTOPE	56.00	28,122	0	2.00
3.00	CT SCAN	57.00	174,981	0	3.00
4.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	49,250	0	4.00
5.00	ULTRASOUND	54.01	0	10,943	5.00
6.00	RADIOISOTOPE	56.00	0	8,872	6.00
7.00	CT SCAN	57.00	0	55,207	7.00
8.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	15,539	8.00
	TOTALS		287,037	90,561	
N - LINEN RECLASS					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	1,504	1.00
2.00	OPERATION OF PLANT	7.00	0	8,681	2.00
3.00	HOUSEKEEPING	9.00	0	89,223	3.00
4.00	DIETARY	10.00	0	1,895	4.00
5.00	CENTRAL SERVICES & SUPPLY	14.00	0	2,803	5.00
6.00	ADULTS & PEDIATRICS	30.00	0	141,772	6.00
7.00	INTENSIVE CARE UNIT	31.00	0	32,658	7.00
8.00	OPERATING ROOM	50.00	0	143,666	8.00
9.00	RADIOLOGY-DIAGNOSTIC	54.00	0	55,734	9.00
10.00	RADIOISOTOPE	56.00	0	1,328	10.00
11.00	CARDIAC CATHETERIZATION	59.00	0	1,476	11.00
12.00	PHYSICAL THERAPY	66.00	0	1,721	12.00
13.00	ELECTROCARDIOLOGY	69.00	0	2,951	13.00
14.00	ELECTROENCEPHALOGRAPHY	70.00	0	2,656	14.00
15.00	WOUND/OSTOMY CLINIC	90.01	0	3,295	15.00
16.00	CTR ADVANCED HEART CARE	90.02	0	1,002	16.00
17.00	EMERGENCY	91.00	0	60,743	17.00
	TOTALS		0	553,108	
500.00	Grand Total: Increases		3,783,528	39,211,762	500.00

RECLASSIFICATIONS

Provider CCN: 15-0113

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

Worksheet A-6
Date/Time Prepared:
5/24/2024 11:54 am

		Decreases					
Cost Center		Line #	Salary	Other	Wkst. A-7 Ref.		
6.00		7.00	8.00	9.00	10.00		
A - Chargeable Medical Supplies							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	0	0		1.00
2.00	OPERATION OF PLANT	7.00	0	0	0		2.00
3.00	HOUSEKEEPING	9.00	0	0	0		3.00
4.00	CENTRAL SERVICES & SUPPLY	14.00	0	46,950	0		4.00
5.00	PHARMACY	15.00	0	31,217	0		5.00
6.00	ADULTS & PEDIATRICS	30.00	0	461,649	0		6.00
7.00	INTENSIVE CARE UNIT	31.00	0	408,628	0		7.00
8.00	OPERATING ROOM	50.00	0	4,745,678	0		8.00
9.00	RADIOLOGY-DIAGNOSTIC	54.00	0	26,612	0		9.00
10.00	ULTRASOUND	54.01	0	15,091	0		10.00
11.00	RADIOISOTOPE	56.00	0	231	0		11.00
12.00	CT SCAN	57.00	0	212,595	0		12.00
13.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	11,844	0		13.00
14.00	CARDIAC CATHETERIZATION	59.00	0	795,029	0		14.00
15.00	LABORATORY	60.00	0	273	0		15.00
16.00	RESPIRATORY THERAPY	65.00	0	110,545	0		16.00
17.00	PHYSICAL THERAPY	66.00	0	149	0		17.00
18.00	ELECTROCARDIOLOGY	69.00	0	10,129	0		18.00
19.00	ELECTROENCEPHALOGRAPHY	70.00	0	119	0		19.00
20.00	RENAL DIALYSIS	74.00	0	7,409	0		20.00
21.00	WOUND/OSTOMY CLINIC	90.01	0	175,647	0		21.00
22.00	CTR ADVANCED HEART CARE	90.02	0	237	0		22.00
23.00	RADIATION ONCOLOGY	90.03	0	110,348	0		23.00
24.00	EMERGENCY	91.00	0	179,430	0		24.00
25.00	WELLNESS CENTERS	190.01	0	25,988	0		25.00
TOTALS			0	7,375,798			
B - Implantable Device Reclass							
1.00	OPERATING ROOM	50.00	0	8,374,104	0		1.00
2.00	CARDIAC CATHETERIZATION	59.00	0	360,004	0		2.00
3.00	WOUND/OSTOMY CLINIC	90.01	0	454	0		3.00
TOTALS			0	8,734,562			
C - Drugs Charges to Pat							
1.00	PHARMACY	15.00	0	7,185,403	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	0	6,300	0		2.00
3.00	INTENSIVE CARE UNIT	31.00	0	4,181	0		3.00
4.00	OPERATING ROOM	50.00	0	4,157	0		4.00
5.00	RADIOLOGY-DIAGNOSTIC	54.00	0	6,873	0		5.00
6.00	ULTRASOUND	54.01	0	50	0		6.00
7.00	RADIOISOTOPE	56.00	0	247,017	0		7.00
8.00	CT SCAN	57.00	0	57,410	0		8.00
9.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	62,300	0		9.00
10.00	CARDIAC CATHETERIZATION	59.00	0	3,430	0		10.00
11.00	LABORATORY	60.00	0	32	0		11.00
12.00	PHYSICAL THERAPY	66.00	0	32	0		12.00
13.00	ELECTROCARDIOLOGY	69.00	0	4,668	0		13.00
14.00	WOUND/OSTOMY CLINIC	90.01	0	2,062	0		14.00
15.00	CTR ADVANCED HEART CARE	90.02	0	323	0		15.00
16.00	RADIATION ONCOLOGY	90.03	0	271	0		16.00
17.00	EMERGENCY	91.00	0	992	0		17.00
18.00	RENAL DIALYSIS	74.00	0	0	0		18.00
19.00	WOUND/OSTOMY CLINIC	90.01	0	0	0		19.00
20.00	CTR ADVANCED HEART CARE	90.02	0	0	0		20.00
21.00	RADIATION ONCOLOGY	90.03	0	0	0		21.00
22.00	EMERGENCY	91.00	0	0	0		22.00
TOTALS			0	7,585,501			
D - Depreciation Expense							
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	720	9		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	610,490	0		2.00
3.00	OPERATION OF PLANT	7.00	0	1,239,128	0		3.00
4.00	HOUSEKEEPING	9.00	0	1,882	0		4.00
5.00	DIETARY	10.00	0	223,167	0		5.00
6.00	NURSING ADMINISTRATION	13.00	0	708	0		6.00
7.00	CENTRAL SERVICES & SUPPLY	14.00	0	65,573	0		7.00
8.00	PHARMACY	15.00	0	5,803	0		8.00
9.00	ADULTS & PEDIATRICS	30.00	0	134,514	0		9.00
10.00	INTENSIVE CARE UNIT	31.00	0	57,862	0		10.00
11.00	OPERATING ROOM	50.00	0	1,333,947	0		11.00
12.00	RADIOLOGY-DIAGNOSTIC	54.00	0	348,097	0		12.00
13.00	ULTRASOUND	54.01	0	2,277	0		13.00
14.00	RADIOISOTOPE	56.00	0	53,601	0		14.00
15.00	CT SCAN	57.00	0	25,942	0		15.00

RECLASSIFICATIONS

Provider CCN: 15-0113

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

Worksheet A-6
Date/Time Prepared:
5/24/2024 11:54 am

Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
16.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	118,577	0	16.00
17.00	CARDIAC CATHETERIZATION	59.00	0	190,474	0	17.00
18.00	LABORATORY	60.00	0	231,913	0	18.00
19.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	62.00	0	2,947	0	19.00
20.00	RESPIRATORY THERAPY	65.00	0	65,373	0	20.00
21.00	PHYSICAL THERAPY	66.00	0	96,321	0	21.00
22.00	ELECTROCARDIOLOGY	69.00	0	120,184	0	22.00
23.00	ELECTROENCEPHALOGRAPHY	70.00	0	27,844	0	23.00
24.00	WOUND/OSTOMY CLINIC	90.01	0	17,448	0	24.00
25.00	CTR ADVANCED HEART CARE	90.02	0	365	0	25.00
26.00	RADIATION ONCOLOGY	90.03	0	802,221	0	26.00
27.00	DIABETIC PLUS CLINIC	90.04	0	2,105	0	27.00
28.00	MAB 3611 REED	90.06	0	2,086	0	28.00
29.00	EMERGENCY	91.00	0	59,245	0	29.00
30.00	WELLNESS CENTERS	190.01	0	148,611	0	30.00
31.00	MONTICELLO HSE.	190.02	0	31,875	0	31.00
32.00	ROCK STEADY BOXING	190.03	0	3,011	0	32.00
33.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	740,441	0	33.00
34.00	MUNCIE MD OFFICES	192.01	0	2,328	0	34.00
35.00	RESIDENTIAL PROPERTY (1430 N MADISON)	192.02	0	3,715	0	35.00
	TOTALS		0	6,770,795		
F - Other Capital Rental						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	1,174	10	1.00
2.00	OPERATION OF PLANT	7.00	0	31,574	0	2.00
3.00	HOUSEKEEPING	9.00	0	10,395	0	3.00
4.00	DIETARY	10.00	0	3,840	0	4.00
5.00	NURSING ADMINISTRATION	13.00	0	128,206	0	5.00
6.00	PHARMACY	15.00	0	300,235	0	6.00
7.00	INTENSIVE CARE UNIT	31.00	0	196	0	7.00
8.00	OPERATING ROOM	50.00	0	327,750	0	8.00
9.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	341,000	0	9.00
10.00	LABORATORY	60.00	0	50,363	0	10.00
11.00	PHYSICAL THERAPY	66.00	0	786,879	0	11.00
12.00	ELECTROENCEPHALOGRAPHY	70.00	0	675	0	12.00
13.00	WOUND/OSTOMY CLINIC	90.01	0	67	0	13.00
14.00	EMERGENCY	91.00	0	196	0	14.00
15.00	WELLNESS CENTERS	190.01	0	205,447	0	15.00
16.00	ROCK STEADY BOXING	190.03	0	19,863	0	16.00
17.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	37,899	0	17.00
18.00	MUNCIE MD OFFICES	192.01	0	21,500	0	18.00
	TOTALS		0	2,267,259		
G - STD BENEFIT RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	98,120	0	0	1.00
2.00	OPERATION OF PLANT	7.00	6,523	0	0	2.00
3.00	PHYSICAL THERAPY	66.00	21,953	0	0	3.00
4.00	DIETARY	10.00	15,343	0	0	4.00
5.00	NURSING ADMINISTRATION	13.00	119	0	0	5.00
6.00	CENTRAL SERVICES & SUPPLY	14.00	1,567	0	0	6.00
7.00	PHARMACY	15.00	3,692	0	0	7.00
8.00	ADULTS & PEDIATRICS	30.00	75,508	0	0	8.00
9.00	INTENSIVE CARE UNIT	31.00	20,367	0	0	9.00
10.00	OPERATING ROOM	50.00	62,301	0	0	10.00
11.00	RADIOLOGY-DIAGNOSTIC	54.00	4,069	0	0	11.00
12.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	1,705	0	0	12.00
13.00	CARDIAC CATHETERIZATION	59.00	101	0	0	13.00
14.00	LABORATORY	60.00	7,557	0	0	14.00
15.00	RESPIRATORY THERAPY	65.00	8,288	0	0	15.00
16.00	PHYSICAL THERAPY	66.00	24,195	0	0	16.00
17.00	ELECTROCARDIOLOGY	69.00	12,899	0	0	17.00
18.00	ELECTROENCEPHALOGRAPHY	70.00	4,181	0	0	18.00
19.00	RADIATION ONCOLOGY	90.03	3,648	0	0	19.00
20.00	EMERGENCY	91.00	2,019	0	0	20.00
21.00	WELLNESS CENTERS	190.01	860	0	0	21.00
	TOTALS		375,015	0	0	
H - Therapy Recl class						
1.00	PHYSICAL THERAPY	66.00	561,377	0	0	1.00
2.00		0.00	0	0	0	2.00
3.00	PHYSICAL THERAPY	66.00	0	167,478	0	3.00
4.00		0.00	0	0	0	4.00

		Decreases				
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
	TOTALS		561,377	167,478		
I - Labor and Delivery						
1.00	ADULTS & PEDIATRICS	30.00	1,739,313	0	0	1.00
2.00		0.00	0	0	0	2.00
3.00	ADULTS & PEDIATRICS	30.00	0	1,236,152	0	3.00
4.00		0.00	0	0	0	4.00
	TOTALS		1,739,313	1,236,152		
J - Cafeteria						
1.00	DIETARY	10.00	1,195,801	0	0	1.00
2.00	DIETARY	10.00	0	1,135,665	0	2.00
	TOTALS		1,195,801	1,135,665		
K - Building Depreciation						
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	2,774,078	9	1.00
	TOTALS		0	2,774,078		
L - Capital Insurance Costs						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	145,790	12	1.00
	TOTALS		0	145,790		
M - Radiology Support Staff						
1.00	RADIOLOGY-DIAGNOSTIC	54.00	287,037	0	0	1.00
2.00		0.00	0	0	0	2.00
3.00		0.00	0	0	0	3.00
4.00		0.00	0	0	0	4.00
5.00	RADIOLOGY-DIAGNOSTIC	54.00	0	90,561	0	5.00
6.00		0.00	0	0	0	6.00
7.00		0.00	0	0	0	7.00
8.00		0.00	0	0	0	8.00
	TOTALS		287,037	90,561		
N - LINEN RECLASS						
1.00	LAUNDRY & LINEN SERVICE	8.00	0	553,108	0	1.00
2.00		0.00	0	0	0	2.00
3.00		0.00	0	0	0	3.00
4.00		0.00	0	0	0	4.00
5.00		0.00	0	0	0	5.00
6.00		0.00	0	0	0	6.00
7.00		0.00	0	0	0	7.00
8.00		0.00	0	0	0	8.00
9.00		0.00	0	0	0	9.00
10.00		0.00	0	0	0	10.00
11.00		0.00	0	0	0	11.00
12.00		0.00	0	0	0	12.00
13.00		0.00	0	0	0	13.00
14.00		0.00	0	0	0	14.00
15.00		0.00	0	0	0	15.00
16.00		0.00	0	0	0	16.00
17.00		0.00	0	0	0	17.00
	TOTALS		0	553,108		
500.00	Grand Total: Decreases		4,158,543	38,836,747		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-0113

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

Worksheet A-7
Part I
Date/Time Prepared:
5/24/2024 11:54 am

	Beginning Balances	Acquisitions			Disposals and Retirements	
		Purchases	Donation	Total		
	1.00	2.00	3.00	4.00	5.00	
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	6,268,153	0	0	0	1.00
2.00	Land Improvements	2,023,177	266,000	0	266,000	2.00
3.00	Buildings and Fixtures	82,665,381	5,802,621	0	5,802,621	3.00
4.00	Building Improvements	2,763,325	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	5.00
6.00	Movable Equipment	82,518,351	5,128,287	0	5,128,287	6.00
7.00	HIT designated Assets	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	176,238,387	11,196,908	0	11,196,908	8.00
9.00	Reconciling Items	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	176,238,387	11,196,908	0	11,196,908	10.00
	Ending Balance		Fully Depreciated Assets			
	6.00		7.00			
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	6,268,153	0			1.00
2.00	Land Improvements	2,289,177	0			2.00
3.00	Buildings and Fixtures	86,480,043	0			3.00
4.00	Building Improvements	2,763,325	0			4.00
5.00	Fixed Equipment	0	0			5.00
6.00	Movable Equipment	86,624,922	0			6.00
7.00	HIT designated Assets	0	0			7.00
8.00	Subtotal (sum of lines 1-7)	184,425,620	0			8.00
9.00	Reconciling Items	0	0			9.00
10.00	Total (line 8 minus line 9)	184,425,620	0			10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-0113

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

Worksheet A-7
Part II
Date/Time Prepared:
5/24/2024 11:54 am

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	0	0				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	0				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-0113

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

Worksheet A-7
Part III
Date/Time Prepared:
5/24/2024 11:54 am

Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL			
	Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance		
	1.00	2.00	3.00	4.00	5.00		
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	97,800,699	0	97,800,699	0.530299	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	86,624,922	0	86,624,922	0.469701	0	2.00
3.00	Total (sum of lines 1-2)	184,425,621	0	184,425,621	1.000000	0	3.00
Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL			
	Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease		
	6.00	7.00	8.00	9.00	10.00		
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	2,774,078	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	8,110,782	2,267,192	2.00
3.00	Total (sum of lines 1-2)	0	0	0	10,884,860	2,267,192	3.00
Cost Center Description	SUMMARY OF CAPITAL						
	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of 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	145,790	0	0	2,919,868	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	10,377,974	2.00
3.00	Total (sum of lines 1-2)	0	145,790	0	0	13,297,842	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 15-0113

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

Worksheet A-8

Date/Time Prepared:
5/24/2024 11:54 am

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted				
			Cost Center		Line #	Wkst. A-7 Ref.	
			1.00	2.00	3.00	4.00	5.00
1.00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00 Investment income - other (chapter 2)			0		0.00	0	3.00
4.00 Trade, quantity, and time discounts (chapter 8)			0	ADMINISTRATIVE & GENERAL	5.00	0	4.00
5.00 Refunds and rebates of expenses (chapter 8)	B	-12,987	0	ADMINISTRATIVE & GENERAL	5.00	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	-182,083	0		0.00	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	-11,099,165	0		0.00	0	12.00
13.00 Laundry and linen service			0		0.00	0	13.00
14.00 Cafeteria-employees and guests	B	-1,101,369	0	CAFETERIA	11.00	0	14.00
15.00 Rental of quarters to employee and others			0		0.00	0	15.00
16.00 Sale of medical and surgical supplies to other than patients			0		0.00	0	16.00
17.00 Sale of drugs to other than patients			0		0.00	0	17.00
18.00 Sale of medical records and abstracts	B		0	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00 Nursing and allied health education (tuition, fees, books, etc.)			0		0.00	0	19.00
20.00 Vending machines			0		0.00	0	20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)			0		0.00	0	21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments			0		0.00	0	22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		0	RESPIRATORY THERAPY	65.00		23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		0	PHYSICAL THERAPY	66.00		24.00
25.00 Utilization review - physicians' compensation (chapter 21)			0	*** Cost Center Deleted ***	114.00		25.00
26.00 Depreciation - CAP REL COSTS-BLDG & FIXT			0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP			0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00 Non-physician Anesthetist	A		0	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00 Physicians' assistant			0		0.00	0	29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		0	OCCUPATIONAL THERAPY	67.00		30.00
30.99 Hospice (non-distinct) (see instructions)			0	ADULTS & PEDIATRICS	30.00		30.99
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		0	SPEECH PATHOLOGY	68.00		31.00
32.00 CAH HIT Adjustment for Depreciation and Interest			0		0.00	0	32.00
33.00 Misc Rev Sales	B	-375,491	0	ADMINISTRATIVE & GENERAL	5.00	0	33.00

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			Wkst. A-7 Ref.
			Cost Center		Line #	
			1.00	2.00	3.00	
33.01 Investment Income	B	-1,946,969	ADMINISTRATIVE & GENERAL		5.00	9 33.01
33.02 Space Rental Income	B	-68,596	ADMINISTRATIVE & GENERAL		5.00	0 33.02
33.03 Space Rental Income	B	-568,140	RADIATION ONCOLOGY		90.03	0 33.03
33.04 Loss on Assets	A	-833	ADMINISTRATIVE & GENERAL		5.00	0 33.04
33.05 Misc Revenue	B	-520	EMPLOYEE BENEFITS DEPARTMENT		4.00	0 33.05
33.06 Misc Revenue	B	-1,120,800	ADMINISTRATIVE & GENERAL		5.00	0 33.06
33.07 Misc Revenue	B	-14,442	CAFETERIA		11.00	0 33.07
33.08 Misc Revenue	B	-1,050	MEDICAL RECORDS & LIBRARY		16.00	0 33.08
33.09 Misc Revenue	B	-1,620	LABORATORY		60.00	0 33.09
33.10 Misc Revenue	B		LABORATORY		60.00	0 33.10
34.00 HAF Tax Offset	A	-14,667,781	ADMINISTRATIVE & GENERAL		5.00	0 34.00
34.01 Sponsorship	A	-481,848	ADMINISTRATIVE & GENERAL		5.00	0 34.01
34.02 Hospitalist Loss	A	-3,088,310	ADMINISTRATIVE & GENERAL		5.00	0 34.02
34.03 Hospitalist Loss	A	-1,056,498	ADULTS & PEDIATRICS		30.00	0 34.03
34.04 Hospitalist Loss	A	-3,524,739	OPERATING ROOM		50.00	0 34.04
34.05 APP	A	-567	ADULTS & PEDIATRICS		30.00	0 34.05
34.06 APP	A	-761	INTENSIVE CARE UNIT		31.00	0 34.06
34.07 APP	A	-3,260	RESPIRATORY THERAPY		65.00	0 34.07
34.08 APP	A	-61	PHYSICAL THERAPY		66.00	0 34.08
34.09 APP	A	-311,809	CTR ADVANCED HEART CARE		90.02	0 34.09
34.10 APP	A	-6,484	RADIATION ONCOLOGY		90.03	0 34.10
35.00 Bad Debt	A	-10,255,683	ADMINISTRATIVE & GENERAL		5.00	0 35.00
36.01 Non Allow Marketing	A	-3,429	ADMINISTRATIVE & GENERAL		5.00	0 36.01
36.02 EPIC Amortization	A	2,823,324	CAP REL COSTS-MVBLE EQUIP		2.00	9 36.02
36.03 EPIC Amortization	A		ADMINISTRATIVE & GENERAL		5.00	0 36.03
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-47,071,971				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: 15-0113

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

Worksheet A-8-1

Date/Time Prepared:
5/24/2024 11:54 am

Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	21.00	I&R SERVICES-SALARY & FRINGE	RESIDENTS	14,234	0 1.00
2.00	22.00	I&R SERVICES-OTHER PRGM. COS	RESIDENTS	33,648	0 2.00
3.00	2.00	CAP REL COSTS-MVBLE EQUIP	HOME OFFICE	1,290,741	0 3.00
3.01	4.00	EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE	2,616,486	0 3.01
3.02	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE	21,353,121	40,151,038 3.02
3.03	13.00	NURSING ADMINISTRATION	HOME OFFICE	1,516,689	0 3.03
3.04	14.00	CENTRAL SERVICES & SUPPLY	HOME OFFICE	472,494	0 3.04
3.05	16.00	MEDICAL RECORDS & LIBRARY	HOME OFFICE	1,069,570	0 3.05
3.06	30.00	ADULTS & PEDIATRICS	HOME OFFICE	388,646	0 3.06
3.07	54.00	RADIOLOGY-DIAGNOSTIC	HOME OFFICE	119,517	0 3.07
3.08	5.00	ADMINISTRATIVE & GENERAL	CPN MEDICAL DIRECTOR	22,282	0 3.08
3.09	91.00	EMERGENCY	CPN CALL	154,445	0 3.09
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.			29,051,873	40,151,038 5.00

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

Symbol (1)	Name	Percentage of Ownership	Related Organization(s) and/or Home Office	
			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	A	IN PROHEALTH	100.00	0.00	6.00
7.00	B	CHNW	100.00	0.00	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:				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: 15-0113

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

Worksheet A-8-1

Date/Time Prepared:
5/24/2024 11:54 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	14,234	0		1.00
2.00	33,648	0		2.00
3.00	1,290,741	9		3.00
3.01	2,616,486	0		3.01
3.02	-18,797,917	0		3.02
3.03	1,516,689	0		3.03
3.04	472,494	0		3.04
3.05	1,069,570	0		3.05
3.06	388,646	0		3.06
3.07	119,517	0		3.07
3.08	22,282	0		3.08
3.09	154,445	0		3.09
4.00	0	0		4.00
5.00	-11,099,165			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			6.00
7.00			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: 15-0113

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

Worksheet A-8-2

Date/Time Prepared:
5/24/2024 11:54 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	164,525	164,525	0	0	0	1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	17,558	17,558	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		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			182,083	182,083	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0	0	1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
	1.00	2.00	15.00	16.00	17.00	18.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	164,525	1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	17,558	2.00
3.00	0.00		0	0	0	0	3.00
4.00	0.00		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	182,083	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0113

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

Worksheet B
Part I
Date/Time Prepared:
5/24/2024 11:54 am

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		BLDG & FIXT	MVBLE EQUIP			
	0	1.00	2.00	4.00	4A	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	2,919,868	2,919,868			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	10,377,974		10,377,974		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	2,695,381	30,400	721	2,726,502	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	30,595,803	172,844	4,283,690	276,426	35,328,763
6.00 00600	MAINTENANCE & REPAIRS	0	0	0	0	6.00
7.00 00700	OPERATION OF PLANT	5,513,443	561,251	478,090	71,784	6,624,568
8.00 00800	LAUNDRY & LINEN SERVICE	0	0	0	0	8.00
9.00 00900	HOUSEKEEPING	3,421,739	31,091	12,301	83,998	3,549,129
10.00 01000	DIETARY	1,077,277	34,628	37,718	21,330	1,170,953
11.00 01100	CAFETERIA	1,324,696	83,160	57,049	47,369	1,512,274
12.00 01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00 01300	NURSING ADMINISTRATION	3,722,361	32,473	129,166	65,669	3,949,669
14.00 01400	CENTRAL SERVICES & SUPPLY	1,052,380	77,133	51,967	17,007	1,198,487
15.00 01500	PHARMACY	3,919,869	35,228	306,203	112,447	4,373,747
16.00 01600	MEDICAL RECORDS & LIBRARY	1,089,297	38,175	0	0	1,127,472
17.00 01700	SOCIAL SERVICE	0	0	0	0	17.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
20.00 02000	NURSING PROGRAM	0	0	0	0	20.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD	14,234	0	0	0	14,234
22.00 02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	33,648	0	0	0	33,648
23.00 02300	PARAMED ED PRGM-(EMS)	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	18,727,944	344,876	109,781	528,101	19,710,702
31.00 03100	INTENSIVE CARE UNIT	6,190,679	135,096	56,819	179,340	6,561,934
43.00 04300	NURSERY	1,552,121	99,615	13,038	34,649	1,699,423
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	13,817,142	404,608	1,503,479	306,665	16,031,894
51.00 05100	RECOVERY ROOM	0	0	0	0	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	1,423,344	47,353	11,956	31,774	1,514,427
54.00 05400	RADIOLOGY-DIAGNOSTIC	2,769,127	32,443	291,110	64,301	3,156,981
54.01 05401	ULTRASOUND	855,762	11,770	2,720	24,349	894,601
56.00 05600	RADIOISOTOPE	539,556	15,276	54,061	14,025	622,918
57.00 05700	CT SCAN	1,553,354	59,641	26,857	35,599	1,675,451
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	1,476,571	0	461,097	25,577	1,963,245
59.00 05900	CARDIAC CATHETERIZATION	1,280,232	66,257	166,350	30,859	1,543,698
60.00 06000	LABORATORY	7,660,880	79,013	268,333	99,714	8,107,940
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	843,595	8,680	2,953	8,332	863,560
64.00 06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00 06500	RESPIRATORY THERAPY	2,944,336	2,541	62,750	85,475	3,095,102
66.00 06600	PHYSICAL THERAPY	3,665,900	65,515	879,984	104,083	4,715,482
67.00 06700	OCCUPATIONAL THERAPY	506,798	12,064	2,981	14,261	536,104
68.00 06800	SPEECH PATHOLOGY	259,353	6,068	1,500	7,177	274,098
69.00 06900	ELECTROCARDIOLOGY	1,615,979	148,014	120,419	45,479	1,929,891
70.00 07000	ELECTROENCEPHALOGRAPHY	999,043	35,095	28,575	22,286	1,084,999
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	7,375,798	0	0	0	7,375,798
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	8,734,562	0	0	0	8,734,562
73.00 07300	DRUGS CHARGED TO PATIENTS	7,588,518	0	0	0	7,588,518
74.00 07400	RENAL DIALYSIS	426,861	0	0	0	426,861
77.00 07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	77.00
78.00 07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	0	0	0	0	90.00
90.01 09001	WOUND/OSTOMY CLINIC	1,896,066	55,270	8,006	25,746	1,985,088
90.02 09002	CTR ADVANCED HEART CARE	194,490	0	366	14,289	209,145
90.03 09003	RADIATION ONCOLOGY	3,525,457	10,957	450,585	74,143	4,061,142
90.04 09004	DIABETIC PLUS CLINIC	493,105	0	2,109	15,119	510,333
90.05 09005	ANTI COAGULATION CLINIC	465,541	0	0	13,569	479,110
90.06 09006	MAB 3611 REED	0	0	0	0	90.06
91.00 09100	EMERGENCY	7,357,894	126,315	44,258	197,842	7,726,309
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
102.00 10200	OPIOID TREATMENT PROGRAM	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	174,497,978	2,862,850	9,926,992	2,698,784	173,962,260
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
190.01 19001	WELLNESS CENTERS	788,807	8,151	354,750	23,532	1,175,240
190.02 19002	MONTICELLO HSE.	19,932	0	0	0	19,932

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0113

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

Worksheet B
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Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		BLDG & FIXT	MVBLE EQUIP			
	0	1.00	2.00	4.00	4A	
190.03 19003 ROCK STEADY BOXING	151,505	0	22,918	4,186	178,609	190.03
190.04 19004 DI ABETES MD	136	0	0	0	136	190.04
192.00 19200 PHYSICIANS' PRIVATE OFFICES	1,527,549	48,867	51,772	0	1,628,188	192.00
192.01 19201 MUNCIE MD OFFICES	13,869	0	21,542	0	35,411	192.01
192.02 19202 RESIDENTIAL PROPERTY (1430 N MADISON	2,512	0	0	0	2,512	192.02
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)	177,002,288	2,919,868	10,377,974	2,726,502	177,002,288	202.00

COST ALLOCATION - GENERAL SERVICE COSTS			Provider CCN: 15-0113	Period: From 01/01/2023 To 12/31/2023	Worksheet B Part I Date/Time Prepared: 5/24/2024 11:54 am		
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	35,328,763				5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0			6.00
7.00	00700	OPERATION OF PLANT	1,651,949	0	8,276,517		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	885,036	0	119,387	0	4,553,552
10.00	01000	DIETARY	291,997	0	132,969	0	74,227
11.00	01100	CAFETERIA	377,111	0	319,329	0	178,259
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0
13.00	01300	NURSING ADMINISTRATION	984,917	0	124,695	0	69,609
14.00	01400	CENTRAL SERVICES & SUPPLY	298,863	0	296,185	0	165,339
15.00	01500	PHARMACY	1,090,668	0	135,272	0	75,513
16.00	01600	MEDICAL RECORDS & LIBRARY	281,154	0	146,590	0	81,831
17.00	01700	SOCIAL SERVICE	0	0	0	0	0
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0
20.00	02000	NURSING PROGRAM	0	0	0	0	0
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	3,549	0	0	0	0
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	8,391	0	0	0	0
23.00	02300	PARAMED ED PRGM-(EMS)	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	4,915,262	0	1,324,305	0	739,266
31.00	03100	INTENSIVE CARE UNIT	1,636,330	0	518,763	0	289,589
43.00	04300	NURSERY	423,780	0	382,515	0	213,531
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	3,997,825	0	1,553,675	0	867,308
51.00	05100	RECOVERY ROOM	0	0	0	0	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	377,648	0	181,832	0	101,504
54.00	05400	RADIOLOGY-DIAGNOSTIC	787,247	0	124,578	0	69,543
54.01	05401	ULTRASOUND	223,084	0	45,195	0	25,229
56.00	05600	RADIOISOTOPE	155,335	0	58,659	0	32,745
57.00	05700	CT SCAN	417,802	0	229,018	0	127,844
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	489,569	0	0	0	0
59.00	05900	CARDIAC CATHETERIZATION	384,947	0	254,425	0	142,028
60.00	06000	LABORATORY	2,021,853	0	303,405	0	169,370
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	215,343	0	33,330	0	18,606
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	771,816	0	9,757	0	5,447
66.00	06600	PHYSICAL THERAPY	1,175,886	0	251,576	0	140,437
67.00	06700	OCCUPATIONAL THERAPY	133,687	0	46,326	0	25,861
68.00	06800	SPEECH PATHOLOGY	68,351	0	23,300	0	13,007
69.00	06900	ELECTROCARDIOLOGY	481,251	0	568,368	0	317,280
70.00	07000	ELECTROENCEPHALOGRAPHY	270,563	0	134,764	0	75,229
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,839,281	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,178,112	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	1,892,326	0	0	0	0
74.00	07400	RENAL DIALYSIS	106,445	0	0	0	0
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	0
90.01	09001	WOUND/OSTOMY CLINIC	495,015	0	212,235	0	118,476
90.02	09002	CTR ADVANCED HEART CARE	52,154	0	0	0	0
90.03	09003	RADIATION ONCOLOGY	1,012,715	0	42,072	0	23,486
90.04	09004	DIABETIC PLUS CLINIC	127,260	0	0	0	0
90.05	09005	ANTI COAGULATION CLINIC	119,474	0	0	0	0
90.06	09006	MAB 3611 REED	0	0	0	0	0
91.00	09100	EMERGENCY	1,926,686	0	485,043	0	270,765
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
OTHER REIMBURSABLE COST CENTERS							
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	34,570,682	0	8,057,568	0	4,431,329
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0
190.01	19001	WELLNESS CENTERS	293,066	0	31,301	0	17,473
190.02	19002	MONTECELLO HSE.	4,970	0	0	0	0
190.03	19003	ROCK STEADY BOXING	44,539	0	0	0	0
190.04	19004	DIABETES MD	34	0	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	406,016	0	187,648	0	104,750
192.01	19201	MUNCIE MD OFFICES	8,830	0	0	0	0
192.02	19202	RESIDENTIAL PROPERTY (1430 N MADISON	626	0	0	0	0

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0113

Period:
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Cost Center Description		ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
		5.00	6.00	7.00	8.00	9.00	
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	0	0 201.00
202.00	TOTAL (sum lines 118 through 201)	35,328,763	0	8,276,517	0	4,553,552	202.00

COST ALLOCATION - GENERAL SERVICE COSTS			Provider CCN: 15-0113		Period: From 01/01/2023 To 12/31/2023		Worksheet B Part I Date/Time Prepared: 5/24/2024 11:54 am	
Cost Center Description			DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			10.00	11.00	12.00	13.00	14.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	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	1,670,146					10.00
11.00	01100	CAFETERIA	0	2,386,973				11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0			12.00
13.00	01300	NURSING ADMINISTRATION	0	89,736	0	5,218,626		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	28,715	0	0	1,987,589	14.00
15.00	01500	PHARMACY	0	104,094	0	0	8,125	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING PROGRAM	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(EMS)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,349,135	588,669	0	2,732,539	81,225	30.00
31.00	03100	INTENSIVE CARE UNIT	305,496	168,703	0	787,707	22,088	31.00
43.00	04300	NURSERY	0	32,305	0	151,390	5,115	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	813	333,817	0	1,546,990	174,934	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	28,715	0	0	4,691	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	68,199	0	0	3,700	54.00
54.01	05401	ULTRASOUND	0	17,947	0	0	3,326	54.01
56.00	05600	RADIOISOTOPE	0	10,768	0	0	523	56.00
57.00	05700	CT SCAN	0	35,894	0	0	3,185	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	21,537	0	0	1,324	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	28,715	0	0	10,476	59.00
60.00	06000	LABORATORY	0	147,167	0	0	223,967	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	10,768	0	0	42,453	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	75,378	0	0	9,547	65.00
66.00	06600	PHYSICAL THERAPY	0	139,988	0	0	2,873	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	7,179	0	0	266	67.00
68.00	06800	SPEECH PATHOLOGY	0	3,589	0	0	134	68.00
69.00	06900	ELECTROCARDIOLOGY	0	53,841	0	0	2,293	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	25,126	0	0	2,222	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	598,089	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	708,279	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	1	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	459	74.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND/OSTOMY CLINIC	0	25,126	0	0	10,588	90.01
90.02	09002	CTR ADVANCED HEART CARE	0	14,358	0	0	813	90.02
90.03	09003	RADIATION ONCOLOGY	0	75,378	0	0	10,196	90.03
90.04	09004	DIABETIC PLUS CLINIC	0	17,947	0	0	896	90.04
90.05	09005	ANTICOAGULATION CLINIC	0	14,358	0	0	1,336	90.05
90.06	09006	MAB 3611 REED	0	0	0	0	0	90.06
91.00	09100	EMERGENCY	14,702	211,777	0	0	51,269	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,670,146	2,379,794	0	5,218,626	1,984,393	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	WELLNESS CENTERS	0	0	0	0	433	190.01
190.02	19002	MONTICELLO HSE.	0	0	0	0	0	190.02
190.03	19003	ROCK STEADY BOXING	0	7,179	0	0	403	190.03
190.04	19004	DIABETES MD	0	0	0	0	0	190.04
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	2,360	192.00
192.01	19201	MUNCIE MD OFFICES	0	0	0	0	0	192.01

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0113

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

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Cost Center Description		DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
		10.00	11.00	12.00	13.00	14.00	
192.02	19202 RESIDENTIAL PROPERTY (1430 N MADISON	0	0	0	0	0	192.02
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)	1,670,146	2,386,973	0	5,218,626	1,987,589	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0113

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

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Cost Center Description			PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING PROGRAM	
			15.00	16.00	17.00	19.00	20.00	
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
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	5,787,419					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,637,047				16.00
17.00	01700	SOCIAL SERVICE	0	0	0			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0		19.00
20.00	02000	NURSING PROGRAM	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0		21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	0	0	0	0		22.00
23.00	02300	PARAMED ED PRGM-(EMS)	0	0	0	0		23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	123,020	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	39,211	0	0	0	31.00
43.00	04300	NURSERY	0	9,187	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	353,997	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	8,424	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	31,168	0	0	0	54.00
54.01	05401	ULTRASOUND	0	22,013	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	18,023	0	0	0	56.00
57.00	05700	CT SCAN	0	112,043	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	41,143	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	62,856	0	0	0	59.00
60.00	06000	LABORATORY	0	127,499	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	5,804	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	36,563	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	22,534	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	3,933	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	1,979	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	32,912	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	13,397	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	44,063	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	49,724	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,787,419	115,801	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	2,971	0	0	0	74.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND/OSTOMY CLINIC	0	15,693	0	0	0	90.01
90.02	09002	CTR ADVANCED HEART CARE	0	1,557	0	0	0	90.02
90.03	09003	RADIATION ONCOLOGY	0	114,924	0	0	0	90.03
90.04	09004	DIABETIC PLUS CLINIC	0	595	0	0	0	90.04
90.05	09005	ANTI COAGULATION CLINIC	0	2,467	0	0	0	90.05
90.06	09006	MAB 3611 REED	0	0	0	0	0	90.06
91.00	09100	EMERGENCY	0	223,546	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	5,787,419	1,637,047	0	0	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	WELLNESS CENTERS	0	0	0	0	0	190.01
190.02	19002	MONTICELLO HSE.	0	0	0	0	0	190.02
190.03	19003	ROCK STEADY BOXING	0	0	0	0	0	190.03
190.04	19004	DIABETES MD	0	0	0	0	0	190.04
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	MUNCIE MD OFFICES	0	0	0	0	0	192.01

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0113

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

Worksheet B
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Date/Time Prepared:
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Cost Center Description		PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING PROGRAM	
		15.00	16.00	17.00	19.00	20.00	
192.02	19202 RESIDENTIAL PROPERTY (1430 N MADISON	0	0	0	0	0	0 192.02
200.00	Cross Foot Adjustments						0 200.00
201.00	Negative Cost Centers	0	0	0	0	0	0 201.00
202.00	TOTAL (sum lines 118 through 201)	5,787,419	1,637,047	0	0	0	0 202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0113

Period:
From 01/01/2023
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Cost Center Description	INTERNS & RESIDENTS			PARAMED PRGM-(EMS)	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
	SERVICES-SALARY & FRINGES	SERVICES-OTHER PRGM. COSTS					
	21.00	22.00	23.00				
GENERAL SERVICE COST CENTERS							
1.00 00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00 00500	ADMINISTRATIVE & GENERAL						5.00
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
12.00 01200	MAINTENANCE OF PERSONNEL						12.00
13.00 01300	NURSING ADMINISTRATION						13.00
14.00 01400	CENTRAL SERVICES & SUPPLY						14.00
15.00 01500	PHARMACY						15.00
16.00 01600	MEDICAL RECORDS & LIBRARY						16.00
17.00 01700	SOCIAL SERVICE						17.00
19.00 01900	NONPHYSICIAN ANESTHETISTS						19.00
20.00 02000	NURSING PROGRAM						20.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD	17,783					21.00
22.00 02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD		42,039				22.00
23.00 02300	PARAMED PRGM-(EMS)			0			23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000	ADULTS & PEDIATRICS	11	26	0	31,564,160	-37	30.00
31.00 03100	INTENSIVE CARE UNIT	0	0	0	10,329,821	0	31.00
43.00 04300	NURSERY	0	0	0	2,917,246	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00 05000	OPERATING ROOM	17,772	42,013	0	24,921,038	-59,785	50.00
51.00 05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0	0	2,217,241	0	52.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	0	0	4,241,416	0	54.00
54.01 05401	ULTRASOUND	0	0	0	1,231,395	0	54.01
56.00 05600	RADIO SOTOPE	0	0	0	898,971	0	56.00
57.00 05700	CT SCAN	0	0	0	2,601,237	0	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	2,516,818	0	58.00
59.00 05900	CARDIAC CATHETERIZATION	0	0	0	2,427,145	0	59.00
60.00 06000	LABORATORY	0	0	0	11,101,201	0	60.00
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	1,189,864	0	62.00
64.00 06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00 06500	RESPIRATORY THERAPY	0	0	0	4,003,610	0	65.00
66.00 06600	PHYSICAL THERAPY	0	0	0	6,448,776	0	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	753,356	0	67.00
68.00 06800	SPEECH PATHOLOGY	0	0	0	384,458	0	68.00
69.00 06900	ELECTROCARDIOLOGY	0	0	0	3,385,836	0	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	0	1,606,300	0	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	9,857,231	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	11,670,677	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	15,384,065	0	73.00
74.00 07400	RENAL DIALYSIS	0	0	0	536,736	0	74.00
77.00 07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00 07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS							
90.00 09000	CLINIC	0	0	0	0	0	90.00
90.01 09001	WOUND/OSTOMY CLINIC	0	0	0	2,862,221	0	90.01
90.02 09002	CTR ADVANCED HEART CARE	0	0	0	278,027	0	90.02
90.03 09003	RADIATION ONCOLOGY	0	0	0	5,339,913	0	90.03
90.04 09004	DIABETIC PLUS CLINIC	0	0	0	657,031	0	90.04
90.05 09005	ANTI COAGULATION CLINIC	0	0	0	616,745	0	90.05
90.06 09006	MAB 3611 REED	0	0	0	0	0	90.06
91.00 09100	EMERGENCY	0	0	0	10,910,097	0	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
102.00 10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS							
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	17,783	42,039	0	172,852,632	-59,822	118.00
NONREIMBURSABLE COST CENTERS							
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01 19001	WELLNESS CENTERS	0	0	0	1,517,513	0	190.01
190.02 19002	MONTICELLO HSE.	0	0	0	24,902	0	190.02

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0113

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

Worksheet B
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Cost Center Description	INTERNS & RESIDENTS			PARAMED ED PRGM-(EMS)	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
	SERVICES-SALARY & FRINGES	SERVICES-OTHER PRGM. COSTS					
	21.00	22.00	23.00				
190.03 19003 ROCK STEADY BOXING	0	0	0	230,730	0	190.03	
190.04 19004 DIABETES MD	0	0	0	170	0	190.04	
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	2,328,962	0	192.00	
192.01 19201 MUNCIE MD OFFICES	0	0	0	44,241	0	192.01	
192.02 19202 RESIDENTIAL PROPERTY (1430 N MADISON	0	0	0	3,138	0	192.02	
200.00 Cross Foot Adjustments	0	0	0	0	0	200.00	
201.00 Negative Cost Centers	0	0	0	0	0	201.00	
202.00 TOTAL (sum lines 118 through 201)	17,783	42,039	0	177,002,288	-59,822	202.00	

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0113

Period:
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Cost Center Description		Total	
		26.00	
GENERAL SERVICE COST CENTERS			
1.00	00100 CAP REL COSTS-BLDG & FIXT		1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT		4.00
5.00	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
12.00	01200 MAINTENANCE OF PERSONNEL		12.00
13.00	01300 NURSING ADMINISTRATION		13.00
14.00	01400 CENTRAL SERVICES & SUPPLY		14.00
15.00	01500 PHARMACY		15.00
16.00	01600 MEDICAL RECORDS & LIBRARY		16.00
17.00	01700 SOCIAL SERVICE		17.00
19.00	01900 NONPHYSICIAN ANESTHETISTS		19.00
20.00	02000 NURSING PROGRAM		20.00
21.00	02100 I&R SERVICES-SALARY & FRINGES APPRVD		21.00
22.00	02200 I&R SERVICES-OTHER PRGM. COSTS APPRVD		22.00
23.00	02300 PARAMED ED PRGM-(EMS)		23.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000 ADULTS & PEDIATRICS	31,564,123	30.00
31.00	03100 INTENSIVE CARE UNIT	10,329,821	31.00
43.00	04300 NURSERY	2,917,246	43.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000 OPERATING ROOM	24,861,253	50.00
51.00	05100 RECOVERY ROOM	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	2,217,241	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	4,241,416	54.00
54.01	05401 ULTRASOUND	1,231,395	54.01
56.00	05600 RADIOISOTOPE	898,971	56.00
57.00	05700 CT SCAN	2,601,237	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	2,516,818	58.00
59.00	05900 CARDIAC CATHETERIZATION	2,427,145	59.00
60.00	06000 LABORATORY	11,101,201	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	1,189,864	62.00
64.00	06400 INTRAVENOUS THERAPY	0	64.00
65.00	06500 RESPIRATORY THERAPY	4,003,610	65.00
66.00	06600 PHYSICAL THERAPY	6,448,776	66.00
67.00	06700 OCCUPATIONAL THERAPY	753,356	67.00
68.00	06800 SPEECH PATHOLOGY	384,458	68.00
69.00	06900 ELECTROCARDIOLOGY	3,385,836	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	1,606,300	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	9,857,231	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	11,670,677	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	15,384,065	73.00
74.00	07400 RENAL DIALYSIS	536,736	74.00
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0	77.00
78.00	07800 CAR T-CELL IMMUNOTHERAPY	0	78.00
OUTPATIENT SERVICE COST CENTERS			
90.00	09000 CLINIC	0	90.00
90.01	09001 WOUND/OSTOMY CLINIC	2,862,221	90.01
90.02	09002 CTR ADVANCED HEART CARE	278,027	90.02
90.03	09003 RADIATION ONCOLOGY	5,339,913	90.03
90.04	09004 DIABETIC PLUS CLINIC	657,031	90.04
90.05	09005 ANTI COAGULATION CLINIC	616,745	90.05
90.06	09006 MAB 3611 REED	0	90.06
91.00	09100 EMERGENCY	10,910,097	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		92.00
OTHER REIMBURSABLE COST CENTERS			
102.00	10200 OPIOID TREATMENT PROGRAM	0	102.00
SPECIAL PURPOSE COST CENTERS			
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	172,792,810	118.00
NONREIMBURSABLE COST CENTERS			
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	190.00
190.01	19001 WELLNESS CENTERS	1,517,513	190.01
190.02	19002 MONTICELLO HSE.	24,902	190.02
190.03	19003 ROCK STEADY BOXING	230,730	190.03
190.04	19004 DIABETES MD	170	190.04
192.00	19200 PHYSICIANS' PRIVATE OFFICES	2,328,962	192.00
192.01	19201 MUNCIE MD OFFICES	44,241	192.01
192.02	19202 RESIDENTIAL PROPERTY (1430 N MADISON	3,138	192.02
200.00	Cross Foot Adjustments	0	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0113

Period:
From 01/01/2023
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Cost Center Description		Total	
		26.00	
201.00	Negative Cost Centers	0	201.00
202.00	TOTAL (sum lines 118 through 201)	176,942,466	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-0113	Period: From 01/01/2023 To 12/31/2023	Worksheet B Part II Date/Time Prepared: 5/24/2024 11:54 am
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Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		BLDG & FIXT	MVBLE EQUIP			
		0	1.00			
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	30,400	721	31,121	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	0	172,844	4,283,690	4,456,534	5.00
6.00 00600	MAINTENANCE & REPAIRS	0	0	0	0	6.00
7.00 00700	OPERATION OF PLANT	0	561,251	478,090	1,039,341	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	0	0	0	8.00
9.00 00900	HOUSEKEEPING	0	31,091	12,301	43,392	9.00
10.00 01000	DIETARY	0	34,628	37,718	72,346	10.00
11.00 01100	CAFETERIA	0	83,160	57,049	140,209	11.00
12.00 01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00 01300	NURSING ADMINISTRATION	0	32,473	129,166	161,639	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	77,133	51,967	129,100	14.00
15.00 01500	PHARMACY	0	35,228	306,203	341,431	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	38,175	0	38,175	16.00
17.00 01700	SOCIAL SERVICE	0	0	0	0	17.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
20.00 02000	NURSING PROGRAM	0	0	0	0	20.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	21.00
22.00 02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	0	0	0	0	22.00
23.00 02300	PARAMED ED PRGM-(EMS)	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	0	344,876	109,781	454,657	30.00
31.00 03100	INTENSIVE CARE UNIT	0	135,096	56,819	191,915	31.00
43.00 04300	NURSERY	0	99,615	13,038	112,653	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	0	404,608	1,503,479	1,908,087	50.00
51.00 05100	RECOVERY ROOM	0	0	0	0	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	47,353	11,956	59,309	52.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	32,443	291,110	323,553	54.00
54.01 05401	ULTRASOUND	0	11,770	2,720	14,490	54.01
56.00 05600	RADIOISOTOPE	0	15,276	54,061	69,337	56.00
57.00 05700	CT SCAN	0	59,641	26,857	86,498	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	461,097	461,097	58.00
59.00 05900	CARDIAC CATHETERIZATION	0	66,257	166,350	232,607	59.00
60.00 06000	LABORATORY	0	79,013	268,333	347,346	60.00
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	8,680	2,953	11,633	62.00
64.00 06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00 06500	RESPIRATORY THERAPY	0	2,541	62,750	65,291	65.00
66.00 06600	PHYSICAL THERAPY	0	65,515	879,984	945,499	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	12,064	2,981	15,045	67.00
68.00 06800	SPEECH PATHOLOGY	0	6,068	1,500	7,568	68.00
69.00 06900	ELECTROCARDIOLOGY	0	148,014	120,419	268,433	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	35,095	28,575	63,670	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00 07400	RENAL DIALYSIS	0	0	0	0	74.00
77.00 07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	77.00
78.00 07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	0	0	0	0	90.00
90.01 09001	WOUND/OSTOMY CLINIC	0	55,270	8,006	63,276	90.01
90.02 09002	CTR ADVANCED HEART CARE	0	0	366	366	90.02
90.03 09003	RADIATION ONCOLOGY	0	10,957	450,585	461,542	90.03
90.04 09004	DIABETIC PLUS CLINIC	0	0	2,109	2,109	90.04
90.05 09005	ANTI COAGULATION CLINIC	0	0	0	0	90.05
90.06 09006	MAB 3611 REED	0	0	0	0	90.06
91.00 09100	EMERGENCY	0	126,315	44,258	170,573	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
102.00 10200	OPIOID TREATMENT PROGRAM	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	0	2,862,850	9,926,992	12,789,842	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
190.01 19001	WELLNESS CENTERS	0	8,151	354,750	362,901	190.01
190.02 19002	MONTICELLO HSE.	0	0	0	0	190.02
190.03 19003	ROCK STEADY BOXING	0	0	22,918	22,918	190.03

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0113

Period:
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To 12/31/2023

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Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		BLDG & FIXT	MVBLE EQUIP			
		1.00	2.00			
190.04 19004 DIABETES MD	0	0	0	0	0	190.04
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	48,867	51,772	100,639	0	192.00
192.01 19201 MUNCIE MD OFFICES	0	0	21,542	21,542	0	192.01
192.02 19202 RESIDENTIAL PROPERTY (1430 N MADISON	0	0	0	0	0	192.02
200.00 Cross Foot Adjustments				0	0	200.00
201.00 Negative Cost Centers		0	0	0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	0	2,919,868	10,377,974	13,297,842	31,121	202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 15-0113		Period: From 01/01/2023 To 12/31/2023		Worksheet B Part II Date/Time Prepared: 5/24/2024 11:54 am	
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	4,459,690					5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0				6.00
7.00	00700	OPERATION OF PLANT	208,535	0	1,248,696			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0		8.00
9.00	00900	HOUSEKEEPING	111,723	0	18,012	0	174,086	9.00
10.00	01000	DIETARY	36,860	0	20,061	0	2,838	10.00
11.00	01100	CAFETERIA	47,605	0	48,178	0	6,815	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	124,332	0	18,813	0	2,661	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	37,727	0	44,686	0	6,321	14.00
15.00	01500	PHARMACY	137,681	0	20,409	0	2,887	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	35,492	0	22,116	0	3,128	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING PROGRAM	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	448	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	1,059	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(EMS)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	620,421	0	199,801	0	28,263	30.00
31.00	03100	INTENSIVE CARE UNIT	206,563	0	78,267	0	11,071	31.00
43.00	04300	NURSERY	53,496	0	57,711	0	8,163	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	504,668	0	234,408	0	33,157	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	47,673	0	27,433	0	3,881	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	99,379	0	18,795	0	2,659	54.00
54.01	05401	ULTRASOUND	28,161	0	6,819	0	965	54.01
56.00	05600	RADIOISOTOPE	19,609	0	8,850	0	1,252	56.00
57.00	05700	CT SCAN	52,742	0	34,552	0	4,888	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	61,801	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	48,594	0	38,386	0	5,430	59.00
60.00	06000	LABORATORY	255,230	0	45,775	0	6,475	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	27,184	0	5,029	0	711	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	97,431	0	1,472	0	208	65.00
66.00	06600	PHYSICAL THERAPY	148,439	0	37,956	0	5,369	66.00
67.00	06700	OCCUPATIONAL THERAPY	16,876	0	6,989	0	989	67.00
68.00	06800	SPEECH PATHOLOGY	8,628	0	3,515	0	497	68.00
69.00	06900	ELECTROCARDIOLOGY	60,751	0	85,751	0	12,130	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	34,155	0	20,332	0	2,876	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	232,183	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	274,955	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	238,879	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	13,437	0	0	0	0	74.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND/OSTOMY CLINIC	62,489	0	32,020	0	4,529	90.01
90.02	09002	CTR ADVANCED HEART CARE	6,584	0	0	0	0	90.02
90.03	09003	RADIATION ONCOLOGY	127,841	0	6,348	0	898	90.03
90.04	09004	DIABETIC PLUS CLINIC	16,065	0	0	0	0	90.04
90.05	09005	ANTI COAGULATION CLINIC	15,082	0	0	0	0	90.05
90.06	09006	MAB 3611 REED	0	0	0	0	0	90.06
91.00	09100	EMERGENCY	243,216	0	73,179	0	10,352	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	4,363,994	0	1,215,663	0	169,413	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	WELLNESS CENTERS	36,995	0	4,722	0	668	190.01
190.02	19002	MONTECELLO HSE.	627	0	0	0	0	190.02
190.03	19003	ROCK STEADY BOXING	5,622	0	0	0	0	190.03
190.04	19004	DIABETES MD	4	0	0	0	0	190.04
192.00	19200	PHYSICIANS' PRIVATE OFFICES	51,254	0	28,311	0	4,005	192.00
192.01	19201	MUNCIE MD OFFICES	1,115	0	0	0	0	192.01
192.02	19202	RESIDENTIAL PROPERTY (1430 N MADISON	79	0	0	0	0	192.02

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0113

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

Worksheet B
Part II
Date/Time Prepared:
5/24/2024 11:54 am

Cost Center Description		ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
		5.00	6.00	7.00	8.00	9.00	
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	4,459,690	0	1,248,696	0	174,086	202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 15-0113	Period: From 01/01/2023 To 12/31/2023	Worksheet B Part II Date/Time Prepared: 5/24/2024 11:54 am			
Cost Center	Description	DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY		
		10.00	11.00	12.00	13.00	14.00		
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00	
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00	
5.00	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	132,349				10.00	
11.00	01100	CAFETERIA	0	243,348			11.00	
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0		12.00	
13.00	01300	NURSING ADMINISTRATION	0	9,148		317,343	13.00	
14.00	01400	CENTRAL SERVICES & SUPPLY	0	2,927		0	14.00	
15.00	01500	PHARMACY	0	10,612		0	15.00	
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0		0	16.00	
17.00	01700	SOCIAL SERVICE	0	0		0	17.00	
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0		0	19.00	
20.00	02000	NURSING PROGRAM	0	0		0	20.00	
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0		0	21.00	
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	0	0		0	22.00	
23.00	02300	PARAMED ED PRGM-(EMS)	0	0		0	23.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	106,911	60,013	0	166,165	9,029	30.00
31.00	03100	INTENSIVE CARE UNIT	24,209	17,199	0	47,900	2,455	31.00
43.00	04300	NURSERY	0	3,293	0	9,206	569	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	64	34,032	0	94,072	19,446	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	2,927	0	0	521	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	6,953	0	0	411	54.00
54.01	05401	ULTRASOUND	0	1,830	0	0	370	54.01
56.00	05600	RADIOISOTOPE	0	1,098	0	0	58	56.00
57.00	05700	CT SCAN	0	3,659	0	0	354	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	2,196	0	0	147	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	2,927	0	0	1,165	59.00
60.00	06000	LABORATORY	0	15,003	0	0	24,897	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	1,098	0	0	4,719	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	7,685	0	0	1,061	65.00
66.00	06600	PHYSICAL THERAPY	0	14,272	0	0	319	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	732	0	0	30	67.00
68.00	06800	SPEECH PATHOLOGY	0	366	0	0	15	68.00
69.00	06900	ELECTROCARDIOLOGY	0	5,489	0	0	255	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	2,562	0	0	247	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	66,485	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	78,746	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	51	74.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND/OSTOMY CLINIC	0	2,562	0	0	1,177	90.01
90.02	09002	CTR ADVANCED HEART CARE	0	1,464	0	0	90	90.02
90.03	09003	RADIATION ONCOLOGY	0	7,685	0	0	1,133	90.03
90.04	09004	DIABETIC PLUS CLINIC	0	1,830	0	0	100	90.04
90.05	09005	ANTI COAGULATION CLINIC	0	1,464	0	0	148	90.05
90.06	09006	MAB 3611 REED	0	0	0	0	0	90.06
91.00	09100	EMERGENCY	1,165	21,590	0	0	5,699	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	132,349	242,616	0	317,343	220,600	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	WELLNESS CENTERS	0	0	0	0	48	190.01
190.02	19002	MONTICELLO HSE.	0	0	0	0	0	190.02
190.03	19003	ROCK STEADY BOXING	0	732	0	0	45	190.03
190.04	19004	DIABETES MD	0	0	0	0	0	190.04
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	262	192.00
192.01	19201	MUNCIE MD OFFICES	0	0	0	0	0	192.01

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-0113	Period: From 01/01/2023 To 12/31/2023	Worksheet B Part II Date/Time Prepared: 5/24/2024 11:54 am			
Cost Center Description		DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
		10.00	11.00	12.00	13.00	14.00	
192.02	19202 RESIDENTIAL PROPERTY (1430 N MADISON	0	0	0	0	0	192.02
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)	132,349	243,348	0	317,343	220,955	202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 15-0113		Period: From 01/01/2023 To 12/31/2023		Worksheet B Part II Date/Time Prepared: 5/24/2024 11:54 am	
Cost Center Description			PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING PROGRAM	
			15.00	16.00	17.00	19.00	20.00	
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
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	515,207					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	98,911				16.00
17.00	01700	SOCIAL SERVICE	0	0	0			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0		19.00
20.00	02000	NURSING PROGRAM	0	0	0		0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0			21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	0	0	0			22.00
23.00	02300	PARAMED ED PRGM-(EMS)	0	0	0			23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	7,438	0			30.00
31.00	03100	INTENSIVE CARE UNIT	0	2,371	0			31.00
43.00	04300	NURSERY	0	555	0			43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	21,329	0			50.00
51.00	05100	RECOVERY ROOM	0	0	0			51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	509	0			52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,885	0			54.00
54.01	05401	ULTRASOUND	0	1,331	0			54.01
56.00	05600	RADIOISOTOPE	0	1,090	0			56.00
57.00	05700	CT SCAN	0	6,775	0			57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	2,488	0			58.00
59.00	05900	CARDIAC CATHETERIZATION	0	3,801	0			59.00
60.00	06000	LABORATORY	0	7,709	0			60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	351	0			62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0			64.00
65.00	06500	RESPIRATORY THERAPY	0	2,211	0			65.00
66.00	06600	PHYSICAL THERAPY	0	1,363	0			66.00
67.00	06700	OCCUPATIONAL THERAPY	0	238	0			67.00
68.00	06800	SPEECH PATHOLOGY	0	120	0			68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,990	0			69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	810	0			70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,664	0			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	3,007	0			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	515,207	7,002	0			73.00
74.00	07400	RENAL DIALYSIS	0	180	0			74.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0			77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0			78.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0			90.00
90.01	09001	WOUND/OSTOMY CLINIC	0	949	0			90.01
90.02	09002	CTR ADVANCED HEART CARE	0	94	0			90.02
90.03	09003	RADIATION ONCOLOGY	0	6,949	0			90.03
90.04	09004	DIABETIC PLUS CLINIC	0	36	0			90.04
90.05	09005	ANTI COAGULATION CLINIC	0	149	0			90.05
90.06	09006	MAB 3611 REED	0	0	0			90.06
91.00	09100	EMERGENCY	0	13,517	0			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0			92.00
OTHER REIMBURSABLE COST CENTERS								
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0			102.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	515,207	98,911	0	0	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0			190.00
190.01	19001	WELLNESS CENTERS	0	0	0			190.01
190.02	19002	MONTICELLO HSE.	0	0	0			190.02
190.03	19003	ROCK STEADY BOXING	0	0	0			190.03
190.04	19004	DIABETES MD	0	0	0			190.04
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0			192.00
192.01	19201	MUNCIE MD OFFICES	0	0	0			192.01

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0113

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

Worksheet B
Part II
Date/Time Prepared:
5/24/2024 11:54 am

Cost Center Description		PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING PROGRAM	
		15.00	16.00	17.00	19.00	20.00	
192.02	19202 RESIDENTIAL PROPERTY (1430 N MADISON	0	0	0			192.02
200.00	Cross Foot Adjustments				0		0 200.00
201.00	Negative Cost Centers	0	0	0	0		0 201.00
202.00	TOTAL (sum lines 118 through 201)	515,207	98,911	0	0		0 202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0113

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

Worksheet B
Part II
Date/Time Prepared:
5/24/2024 11:54 am

Cost Center Description	INTERNS & RESIDENTS			PARAMED PRGM-(EMS)	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments
	SERVICES-SALARY & FRINGES	SERVICES-OTHER PRGM. COSTS				
	21.00	22.00	23.00			
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00 00500	ADMINISTRATIVE & GENERAL					5.00
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
12.00 01200	MAINTENANCE OF PERSONNEL					12.00
13.00 01300	NURSING ADMINISTRATION					13.00
14.00 01400	CENTRAL SERVICES & SUPPLY					14.00
15.00 01500	PHARMACY					15.00
16.00 01600	MEDICAL RECORDS & LIBRARY					16.00
17.00 01700	SOCIAL SERVICE					17.00
19.00 01900	NONPHYSICIAN ANESTHETISTS					19.00
20.00 02000	NURSING PROGRAM					20.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD	448				21.00
22.00 02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD		1,059			22.00
23.00 02300	PARAMED PRGM-(EMS)			0		23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS				1,658,719	0 30.00
31.00 03100	INTENSIVE CARE UNIT				583,998	0 31.00
43.00 04300	NURSERY				246,042	0 43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM				2,852,764	0 50.00
51.00 05100	RECOVERY ROOM				0	0 51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM				142,616	0 52.00
54.00 05400	RADIOLOGY-DIAGNOSTIC				454,369	0 54.00
54.01 05401	ULTRASOUND				54,244	0 54.01
56.00 05600	RADIOISOTOPE				101,454	0 56.00
57.00 05700	CT SCAN				189,874	0 57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)				528,021	0 58.00
59.00 05900	CARDIAC CATHETERIZATION				333,262	0 59.00
60.00 06000	LABORATORY				703,573	0 60.00
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD CELLS				50,820	0 62.00
64.00 06400	INTRAVENOUS THERAPY				0	0 64.00
65.00 06500	RESPIRATORY THERAPY				176,335	0 65.00
66.00 06600	PHYSICAL THERAPY				1,154,405	0 66.00
67.00 06700	OCCUPATIONAL THERAPY				41,062	0 67.00
68.00 06800	SPEECH PATHOLOGY				20,791	0 68.00
69.00 06900	ELECTROCARDIOLOGY				435,318	0 69.00
70.00 07000	ELECTROENCEPHALOGRAPHY				124,906	0 70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS				301,332	0 71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS				356,708	0 72.00
73.00 07300	DRUGS CHARGED TO PATIENTS				761,088	0 73.00
74.00 07400	RENAL DIALYSIS				13,668	0 74.00
77.00 07700	ALLOGENEIC HSCT ACQUISITION				0	0 77.00
78.00 07800	CAR T-CELL IMMUNOTHERAPY				0	0 78.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC				0	0 90.00
90.01 09001	WOUND/OSTOMY CLINIC				167,296	0 90.01
90.02 09002	CTR ADVANCED HEART CARE				8,761	0 90.02
90.03 09003	RADIATION ONCOLOGY				613,242	0 90.03
90.04 09004	DIABETIC PLUS CLINIC				20,313	0 90.04
90.05 09005	ANTI COAGULATION CLINIC				16,998	0 90.05
90.06 09006	MAB 3611 REED				0	0 90.06
91.00 09100	EMERGENCY				541,550	0 91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)				0	0 92.00
OTHER REIMBURSABLE COST CENTERS						
102.00 10200	OPIOID TREATMENT PROGRAM				0	0 102.00
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	0	0	0	12,653,529	0 118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN				0	0 190.00
190.01 19001	WELLNESS CENTERS				405,603	0 190.01
190.02 19002	MONTICELLO HSE.				627	0 190.02

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0113

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

Worksheet B
Part II
Date/Time Prepared:
5/24/2024 11:54 am

Cost Center Description	INTERNS & RESIDENTS			Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
	SERVICES-SALARY & FRINGES	SERVICES-OTHER PRGM. COSTS	PARAMED ED PRGM-(EMS)			
	21.00	22.00	23.00			
190.03 19003 ROCK STEADY BOXING				29,365	0	190.03
190.04 19004 DIABETES MD				4	0	190.04
192.00 19200 PHYSICIANS' PRIVATE OFFICES				184,471	0	192.00
192.01 19201 MUNCIE MD OFFICES				22,657	0	192.01
192.02 19202 RESIDENTIAL PROPERTY (1430 N MADISON				79	0	192.02
200.00 Cross Foot Adjustments	448	1,059	0	1,507	0	200.00
201.00 Negative Cost Centers	0	0	0	0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	448	1,059	0	13,297,842	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-0113	Period: From 01/01/2023 To 12/31/2023	Worksheet B Part II Date/Time Prepared: 5/24/2024 11:54 am
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Cost Center Description		Total	
		26.00	
GENERAL SERVICE COST CENTERS			
1.00	00100 CAP REL COSTS-BLDG & FIXT		1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT		4.00
5.00	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
12.00	01200 MAINTENANCE OF PERSONNEL		12.00
13.00	01300 NURSING ADMINISTRATION		13.00
14.00	01400 CENTRAL SERVICES & SUPPLY		14.00
15.00	01500 PHARMACY		15.00
16.00	01600 MEDICAL RECORDS & LIBRARY		16.00
17.00	01700 SOCIAL SERVICE		17.00
19.00	01900 NONPHYSICIAN ANESTHETISTS		19.00
20.00	02000 NURSING PROGRAM		20.00
21.00	02100 I&R SERVICES-SALARY & FRINGES APPRVD		21.00
22.00	02200 I&R SERVICES-OTHER PRGM. COSTS APPRVD		22.00
23.00	02300 PARAMED ED PRGM-(EMS)		23.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000 ADULTS & PEDIATRICS	1,658,719	30.00
31.00	03100 INTENSIVE CARE UNIT	583,998	31.00
43.00	04300 NURSERY	246,042	43.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000 OPERATING ROOM	2,852,764	50.00
51.00	05100 RECOVERY ROOM	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	142,616	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	454,369	54.00
54.01	05401 ULTRASOUND	54,244	54.01
56.00	05600 RADIOISOTOPE	101,454	56.00
57.00	05700 CT SCAN	189,874	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	528,021	58.00
59.00	05900 CARDIAC CATHETERIZATION	333,262	59.00
60.00	06000 LABORATORY	703,573	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	50,820	62.00
64.00	06400 INTRAVENOUS THERAPY	0	64.00
65.00	06500 RESPIRATORY THERAPY	176,335	65.00
66.00	06600 PHYSICAL THERAPY	1,154,405	66.00
67.00	06700 OCCUPATIONAL THERAPY	41,062	67.00
68.00	06800 SPEECH PATHOLOGY	20,791	68.00
69.00	06900 ELECTROCARDIOLOGY	435,318	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	124,906	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	301,332	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	356,708	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	761,088	73.00
74.00	07400 RENAL DIALYSIS	13,668	74.00
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0	77.00
78.00	07800 CAR T-CELL IMMUNOTHERAPY	0	78.00
OUTPATIENT SERVICE COST CENTERS			
90.00	09000 CLINIC	0	90.00
90.01	09001 WOUND/OSTOMY CLINIC	167,296	90.01
90.02	09002 CTR ADVANCED HEART CARE	8,761	90.02
90.03	09003 RADIATION ONCOLOGY	613,242	90.03
90.04	09004 DIABETIC PLUS CLINIC	20,313	90.04
90.05	09005 ANTI COAGULATION CLINIC	16,998	90.05
90.06	09006 MAB 3611 REED	0	90.06
91.00	09100 EMERGENCY	541,550	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		92.00
OTHER REIMBURSABLE COST CENTERS			
102.00	10200 OPIOID TREATMENT PROGRAM	0	102.00
SPECIAL PURPOSE COST CENTERS			
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	12,653,529	118.00
NONREIMBURSABLE COST CENTERS			
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	190.00
190.01	19001 WELLNESS CENTERS	405,603	190.01
190.02	19002 MONTICELLO HSE.	627	190.02
190.03	19003 ROCK STEADY BOXING	29,365	190.03
190.04	19004 DIABETES MD	4	190.04
192.00	19200 PHYSICIANS' PRIVATE OFFICES	184,471	192.00
192.01	19201 MUNICE MD OFFICES	22,657	192.01
192.02	19202 RESIDENTIAL PROPERTY (1430 N MADISON	79	192.02
200.00	Cross Foot Adjustments	1,507	200.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-0113	Period: From 01/01/2023 To 12/31/2023	Worksheet B Part II Date/Time Prepared: 5/24/2024 11:54 am
Cost Center Description		Total		
		26.00		
201.00	Negative Cost Centers	0		201.00
202.00	TOTAL (sum lines 118 through 201)	13,297,842		202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0113

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

Worksheet B-1

Date/Time Prepared:
5/24/2024 11:54 am

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
	1.00	2.00				
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	287,283				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		10,357,757			2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	2,991	720	71,394,932		4.00
5.00 00500	ADMINISTRATIVE & GENERAL	17,006	4,275,345	7,238,354	-35,328,763	141,673,525
6.00 00600	MAINTENANCE & REPAIRS	0	0	0	0	0
7.00 00700	OPERATION OF PLANT	55,221	477,159	1,879,698	0	6,624,568
8.00 00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0
9.00 00900	HOUSEKEEPING	3,059	12,277	2,199,522	0	3,549,129
10.00 01000	DIETARY	3,407	37,645	558,539	0	1,170,953
11.00 01100	CAFETERIA	8,182	56,938	1,240,375	0	1,512,274
12.00 01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0
13.00 01300	NURSING ADMINISTRATION	3,195	128,914	1,719,591	0	3,949,669
14.00 01400	CENTRAL SERVICES & SUPPLY	7,589	51,866	445,334	0	1,198,487
15.00 01500	PHARMACY	3,466	305,606	2,944,496	0	4,373,747
16.00 01600	MEDICAL RECORDS & LIBRARY	3,756	0	0	0	1,127,472
17.00 01700	SOCIAL SERVICE	0	0	0	0	0
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0
20.00 02000	NURSING PROGRAM	0	0	0	0	0
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	14,234
22.00 02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	0	0	0	0	33,648
23.00 02300	PARAMED ED PRGM-(EMS)	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	33,932	109,567	13,828,574	0	19,710,702
31.00 03100	INTENSIVE CARE UNIT	13,292	56,708	4,696,128	0	6,561,934
43.00 04300	NURSERY	9,801	13,013	907,295	0	1,699,423
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	39,809	1,500,550	8,030,188	0	16,031,894
51.00 05100	RECOVERY ROOM	0	0	0	0	0
52.00 05200	DELIVERY ROOM & LABOR ROOM	4,659	11,933	832,018	0	1,514,427
54.00 05400	RADIOLOGY-DIAGNOSTIC	3,192	290,543	1,683,751	0	3,156,981
54.01 05401	ULTRASOUND	1,158	2,715	637,591	0	894,601
56.00 05600	RADIOISOTOPE	1,503	53,956	367,245	0	622,918
57.00 05700	CT SCAN	5,868	26,805	932,189	0	1,675,451
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	460,199	669,737	0	1,963,245
59.00 05900	CARDIAC CATHETERIZATION	6,519	166,026	808,067	0	1,543,698
60.00 06000	LABORATORY	7,774	267,810	2,611,079	0	8,107,940
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	854	2,947	218,188	0	863,560
64.00 06400	INTRAVENOUS THERAPY	0	0	0	0	0
65.00 06500	RESPIRATORY THERAPY	250	62,628	2,238,198	0	3,095,102
66.00 06600	PHYSICAL THERAPY	6,446	878,270	2,725,474	0	4,715,482
67.00 06700	OCCUPATIONAL THERAPY	1,187	2,975	373,436	0	536,104
68.00 06800	SPEECH PATHOLOGY	597	1,497	187,941	0	274,098
69.00 06900	ELECTROCARDIOLOGY	14,563	120,184	1,190,886	0	1,929,891
70.00 07000	ELECTROENCEPHALOGRAPHY	3,453	28,519	583,575	0	1,084,999
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	7,375,798
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	8,734,562
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	7,588,518
74.00 07400	RENAL DIALYSIS	0	0	0	0	426,861
77.00 07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0
78.00 07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	0	0	0	0	0
90.01 09001	WOUND/OSTOMY CLINIC	5,438	7,990	674,178	0	1,985,088
90.02 09002	CTR ADVANCED HEART CARE	0	365	374,161	0	209,145
90.03 09003	RADIATION ONCOLOGY	1,078	449,707	1,941,487	0	4,061,142
90.04 09004	DIABETIC PLUS CLINIC	0	2,105	395,909	0	510,333
90.05 09005	ANTI COAGULATION CLINIC	0	0	355,317	0	479,110
90.06 09006	MAB 3611 REED	0	0	0	0	0
91.00 09100	EMERGENCY	12,428	44,172	5,180,592	0	7,726,309
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					
OTHER REIMBURSABLE COST CENTERS						
102.00 10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	281,673	9,907,654	70,669,113	-35,328,763	138,633,497
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0
190.01 19001	WELLNESS CENTERS	802	354,059	616,202	0	1,175,240
190.02 19002	MONTICELLO HSE.	0	0	0	0	19,932

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0113

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

Worksheet B-1

Date/Time Prepared:
5/24/2024 11:54 am

Cost Center Description		CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)		
		BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)					
		1.00	2.00	4.00	5A	5.00		
190.03	19003	ROCK STEADY BOXING	0	22,873	109,617	0	178,609	190.03
190.04	19004	DIABETES MD	0	0	0	0	136	190.04
192.00	19200	PHYSICIANS' PRIVATE OFFICES	4,808	51,671	0	0	1,628,188	192.00
192.01	19201	MUNCIE MD OFFICES	0	21,500	0	0	35,411	192.01
192.02	19202	RESIDENTIAL PROPERTY (1430 N MADISON	0	0	0	0	2,512	192.02
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)	2,919,868	10,377,974	2,726,502		35,328,763	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	10.163734	1.001952	0.038189		0.249367	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			31,121		4,459,690	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000436		0.031479	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: 15-0113

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

Worksheet B-1

Date/Time Prepared:
5/24/2024 11:54 am

Cost Center Description		MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DAYS DIETARY)	
		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	0				6.00
7.00	00700	OPERATION OF PLANT	0	212,065			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0		8.00
9.00	00900	HOUSEKEEPING	0	3,059	0	209,006	9.00
10.00	01000	DIETARY	0	3,407	0	3,407	22,606
11.00	01100	CAFETERIA	0	8,182	0	8,182	0
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0
13.00	01300	NURSING ADMINISTRATION	0	3,195	0	3,195	0
14.00	01400	CENTRAL SERVICES & SUPPLY	0	7,589	0	7,589	0
15.00	01500	PHARMACY	0	3,466	0	3,466	0
16.00	01600	MEDICAL RECORDS & LIBRARY	0	3,756	0	3,756	0
17.00	01700	SOCIAL SERVICE	0	0	0	0	0
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0
20.00	02000	NURSING PROGRAM	0	0	0	0	0
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	0	0	0	0	0
23.00	02300	PARAMED ED PRGM-(EMS)	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	33,932	0	33,932	18,261
31.00	03100	INTENSIVE CARE UNIT	0	13,292	0	13,292	4,135
43.00	04300	NURSERY	0	9,801	0	9,801	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	39,809	0	39,809	11
51.00	05100	RECOVERY ROOM	0	0	0	0	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	4,659	0	4,659	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,192	0	3,192	0
54.01	05401	ULTRASOUND	0	1,158	0	1,158	0
56.00	05600	RADIOISOTOPE	0	1,503	0	1,503	0
57.00	05700	CT SCAN	0	5,868	0	5,868	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0
59.00	05900	CARDIAC CATHETERIZATION	0	6,519	0	6,519	0
60.00	06000	LABORATORY	0	7,774	0	7,774	0
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	854	0	854	0
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	0	250	0	250	0
66.00	06600	PHYSICAL THERAPY	0	6,446	0	6,446	0
67.00	06700	OCCUPATIONAL THERAPY	0	1,187	0	1,187	0
68.00	06800	SPEECH PATHOLOGY	0	597	0	597	0
69.00	06900	ELECTROCARDIOLOGY	0	14,563	0	14,563	0
70.00	07000	ELECTROENCEPHALOGRAPHY	0	3,453	0	3,453	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
74.00	07400	RENAL DIALYSIS	0	0	0	0	0
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	0
90.01	09001	WOUND/OSTOMY CLINIC	0	5,438	0	5,438	0
90.02	09002	CTR ADVANCED HEART CARE	0	0	0	0	0
90.03	09003	RADIATION ONCOLOGY	0	1,078	0	1,078	0
90.04	09004	DIABETIC PLUS CLINIC	0	0	0	0	0
90.05	09005	ANTI COAGULATION CLINIC	0	0	0	0	0
90.06	09006	MAB 3611 REED	0	0	0	0	0
91.00	09100	EMERGENCY	0	12,428	0	12,428	199
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0
OTHER REIMBURSABLE COST CENTERS							
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	206,455	0	203,396	22,606
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0
190.01	19001	WELLNESS CENTERS	0	802	0	802	0
190.02	19002	MONTICELLO HSE.	0	0	0	0	0
190.03	19003	ROCK STEADY BOXING	0	0	0	0	0
190.04	19004	DIABETES MD	0	0	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	4,808	0	4,808	0

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0113

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

Worksheet B-1

Date/Time Prepared:
5/24/2024 11:54 am

Cost Center Description			MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DAYS DIETARY)	
			6.00	7.00	8.00	9.00	10.00	
192.01	19201	MUNCIE MD OFFICES	0	0	0	0	0	192.01
192.02	19202	RESIDENTIAL PROPERTY (1430 N MADISON	0	0	0	0	0	192.02
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)	0	8,276,517	0	4,553,552	1,670,146	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	39.028208	0.000000	21.786705	73.880651	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0	1,248,696	0	174,086	132,349	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	5.888270	0.000000	0.832923	5.854596	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: 15-0113

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

Worksheet B-1

Date/Time Prepared:
5/24/2024 11:54 am

Cost Center Description		CAFETERIA (ONSITE FTES)	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
		11.00	12.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600						6.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	665					11.00
12.00	01200	0	0				12.00
13.00	01300	25	0	650,855			13.00
14.00	01400	8	0	0	24,511,367		14.00
15.00	01500	29	0	0	100,201	7,638,097	15.00
16.00	01600	0	0	0	0	0	16.00
17.00	01700	0	0	0	0	0	17.00
19.00	01900	0	0	0	0	0	19.00
20.00	02000	0	0	0	0	0	20.00
21.00	02100	0	0	0	0	0	21.00
22.00	02200	0	0	0	0	0	22.00
23.00	02300	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	164	0	340,796	1,001,693	0	30.00
31.00	03100	47	0	98,241	272,392	0	31.00
43.00	04300	9	0	18,881	63,085	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	93	0	192,937	2,157,332	0	50.00
51.00	05100	0	0	0	0	0	51.00
52.00	05200	8	0	0	57,851	0	52.00
54.00	05400	19	0	0	45,624	0	54.00
54.01	05401	5	0	0	41,015	0	54.01
56.00	05600	3	0	0	6,447	0	56.00
57.00	05700	10	0	0	39,280	0	57.00
58.00	05800	6	0	0	16,334	0	58.00
59.00	05900	8	0	0	129,191	0	59.00
60.00	06000	41	0	0	2,762,025	0	60.00
62.00	06200	3	0	0	523,538	0	62.00
64.00	06400	0	0	0	0	0	64.00
65.00	06500	21	0	0	117,734	0	65.00
66.00	06600	39	0	0	35,436	0	66.00
67.00	06700	2	0	0	3,286	0	67.00
68.00	06800	1	0	0	1,654	0	68.00
69.00	06900	15	0	0	28,278	0	69.00
70.00	07000	7	0	0	27,406	0	70.00
71.00	07100	0	0	0	7,375,798	0	71.00
72.00	07200	0	0	0	8,734,561	0	72.00
73.00	07300	0	0	0	17	7,638,097	73.00
74.00	07400	0	0	0	5,658	0	74.00
77.00	07700	0	0	0	0	0	77.00
78.00	07800	0	0	0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	0	0	0	0	90.00
90.01	09001	7	0	0	130,577	0	90.01
90.02	09002	4	0	0	10,024	0	90.02
90.03	09003	21	0	0	125,743	0	90.03
90.04	09004	5	0	0	11,047	0	90.04
90.05	09005	4	0	0	16,473	0	90.05
90.06	09006	0	0	0	0	0	90.06
91.00	09100	59	0	0	632,259	0	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
102.00	10200	0	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS							
118.00		663	0	650,855	24,471,959	7,638,097	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
190.01	19001	0	0	0	5,339	0	190.01
190.02	19002	0	0	0	0	0	190.02
190.03	19003	2	0	0	4,969	0	190.03
190.04	19004	0	0	0	0	0	190.04

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0113

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

Worksheet B-1

Date/Time Prepared:
5/24/2024 11:54 am

Cost Center Description		CAFETERIA (ONSITE FTES)	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
		11.00	12.00	13.00	14.00	15.00	
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
192.01	19201	MUNCIE MD OFFICES	0	0	0	0	192.01
192.02	19202	RESIDENTIAL PROPERTY (1430 N MADISON	0	0	0	0	192.02
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)	2,386,973	0	5,218,626	1,987,589	5,787,419
203.00		Unit cost multiplier (Wkst. B, Part I)	3,589.433083	0.000000	8.018108	0.081088	0.757704
204.00		Cost to be allocated (per Wkst. B, Part II)	243,348	0	317,343	220,955	515,207
205.00		Unit cost multiplier (Wkst. B, Part II)	365.936842	0.000000	0.487579	0.009014	0.067452
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: 15-0113

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

Worksheet B-1
Date/Time Prepared:
5/24/2024 11:54 am

Cost Center Description	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	NURSING PROGRAM (ASSIGNED TIME)	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES (ASSIGNED TIME)	
	16.00	17.00	19.00	20.00	21.00	
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
12.00 01200 MAINTENANCE OF PERSONNEL						12.00
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	846,129,277					16.00
17.00 01700 SOCIAL SERVICE	0	0				17.00
19.00 01900 NONPHYSICIAN ANESTHETISTS	0	0	0			19.00
20.00 02000 NURSING PROGRAM	0	0		0		20.00
21.00 02100 I&R SERVICES-SALARY & FRINGES APPRVD	0	0			1,601	21.00
22.00 02200 I&R SERVICES-OTHER PRGM. COSTS APPRVD	0	0				22.00
23.00 02300 PARAMED ED PRGM-(EMS)	0	0				23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS	63,576,477	0	0	0		30.00
31.00 03100 INTENSIVE CARE UNIT	20,264,275	0	0	0		31.00
43.00 04300 NURSERY	4,747,590	0	0	0		43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	183,054,348	0	0	0	1,600	50.00
51.00 05100 RECOVERY ROOM	0	0	0	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	4,353,685	0	0	0	0	52.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	16,107,325	0	0	0	0	54.00
54.01 05401 ULTRASOUND	11,376,053	0	0	0	0	54.01
56.00 05600 RADIOISOTOPE	9,314,412	0	0	0	0	56.00
57.00 05700 CT SCAN	57,903,138	0	0	0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	21,262,700	0	0	0	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	32,483,880	0	0	0	0	59.00
60.00 06000 LABORATORY	65,891,138	0	0	0	0	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	2,999,456	0	0	0	0	62.00
64.00 06400 INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00 06500 RESPIRATORY THERAPY	18,895,822	0	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	11,645,523	0	0	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	2,032,424	0	0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	1,022,920	0	0	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	17,008,533	0	0	0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	6,923,673	0	0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	22,771,440	0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	25,697,053	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	59,845,486	0	0	0	0	73.00
74.00 07400 RENAL DIALYSIS	1,535,261	0	0	0	0	74.00
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00 07800 CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000 CLINIC	0	0	0	0	0	90.00
90.01 09001 WOUND/OSTOMY CLINIC	8,110,133	0	0	0	0	90.01
90.02 09002 CTR ADVANCED HEART CARE	804,837	0	0	0	0	90.02
90.03 09003 RADIATION ONCOLOGY	59,392,100	0	0	0	0	90.03
90.04 09004 DIABETIC PLUS CLINIC	307,237	0	0	0	0	90.04
90.05 09005 ANTI COAGULATION CLINIC	1,274,812	0	0	0	0	90.05
90.06 09006 MAB 3611 REED	0	0	0	0	0	90.06
91.00 09100 EMERGENCY	115,527,546	0	0	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS						
102.00 10200 OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	846,129,277	0	0	1,601	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01 19001 WELLNESS CENTERS	0	0	0	0	0	190.01
190.02 19002 MONTICELLO HSE.	0	0	0	0	0	190.02

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0113

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

Worksheet B-1

Date/Time Prepared:
5/24/2024 11:54 am

Cost Center Description		MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	NURSING PROGRAM (ASSIGNED TIME)	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES (ASSIGNED TIME)	
		16.00	17.00	19.00	20.00	21.00	
190.03	19003 ROCK STEADY BOXING	0	0	0	0	0	190.03
190.04	19004 DIABETES MD	0	0	0	0	0	190.04
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201 MUNCIE MD OFFICES	0	0	0	0	0	192.01
192.02	19202 RESIDENTIAL PROPERTY (1430 N MADISON	0	0	0	0	0	192.02
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)	1,637,047	0	0	0	17,783	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	0.001935	0.000000	0.000000	0.000000	11.107433	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	98,911	0	0	0	448	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.000117	0.000000	0.000000	0.000000	0.279825	205.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)				0		206.00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)				0.000000		207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0113

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

Worksheet B-1
Date/Time Prepared:
5/24/2024 11:54 am

Cost Center Description	INTERNS & RESIDENTS	PARAMED PRGM-(EMS) (ASSIGNED TIME)	
	SERVICES-OTHER PRGM. COSTS (ASSIGNED TIME)		
	22.00		
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
12.00 01200 MAINTENANCE OF PERSONNEL			12.00
13.00 01300 NURSING ADMINISTRATION			13.00
14.00 01400 CENTRAL SERVICES & SUPPLY			14.00
15.00 01500 PHARMACY			15.00
16.00 01600 MEDICAL RECORDS & LIBRARY			16.00
17.00 01700 SOCIAL SERVICE			17.00
19.00 01900 NONPHYSICIAN ANESTHETISTS			19.00
20.00 02000 NURSING PROGRAM			20.00
21.00 02100 I&R SERVICES-SALARY & FRINGES APPRVD			21.00
22.00 02200 I&R SERVICES-OTHER PRGM. COSTS APPRVD	1,601		22.00
23.00 02300 PARAMED PRGM-(EMS)		0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00 03000 ADULTS & PEDIATRICS	1	0	30.00
31.00 03100 INTENSIVE CARE UNIT	0	0	31.00
43.00 04300 NURSERY	0	0	43.00
ANCILLARY SERVICE COST CENTERS			
50.00 05000 OPERATING ROOM	1,600	0	50.00
51.00 05100 RECOVERY ROOM	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	52.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	54.00
54.01 05401 ULTRASOUND	0	0	54.01
56.00 05600 RADIOISOTOPE	0	0	56.00
57.00 05700 CT SCAN	0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	59.00
60.00 06000 LABORATORY	0	0	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	62.00
64.00 06400 INTRAVENOUS THERAPY	0	0	64.00
65.00 06500 RESPIRATORY THERAPY	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0	0	66.00
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 IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	73.00
74.00 07400 RENAL DIALYSIS	0	0	74.00
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0	0	77.00
78.00 07800 CAR T-CELL IMMUNOTHERAPY	0	0	78.00
OUTPATIENT SERVICE COST CENTERS			
90.00 09000 CLINIC	0	0	90.00
90.01 09001 WOUND/OSTOMY CLINIC	0	0	90.01
90.02 09002 CTR ADVANCED HEART CARE	0	0	90.02
90.03 09003 RADIATION ONCOLOGY	0	0	90.03
90.04 09004 DIABETIC PLUS CLINIC	0	0	90.04
90.05 09005 ANTI COAGULATION CLINIC	0	0	90.05
90.06 09006 MAB 3611 REED	0	0	90.06
91.00 09100 EMERGENCY	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
OTHER REIMBURSABLE COST CENTERS			
102.00 10200 OPIOID TREATMENT PROGRAM	0	0	102.00
SPECIAL PURPOSE COST CENTERS			
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	1,601	0
NONREIMBURSABLE COST CENTERS			
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
190.01 19001 WELLNESS CENTERS	0	0	190.01
190.02 19002 MONTICELLO HSE.	0	0	190.02
190.03 19003 ROCK STEADY BOXING	0	0	190.03

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0113

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

Worksheet B-1

Date/Time Prepared:
5/24/2024 11:54 am

Cost Center Description	INTERNS & RESIDENTS	PARAMED PRGM- (EMS) (ASSIGNED TIME)	
	SERVICES-OTHER PRGM. COSTS (ASSIGNED TIME)		
	22.00		
190.04 19004 DIABETES MD	0	0	190.04
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	192.00
192.01 19201 MUNCIE MD OFFICES	0	0	192.01
192.02 19202 RESIDENTIAL PROPERTY (1430 N MADISON	0	0	192.02
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)	42,039	0	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	26.257964	0.000000	203.00
204.00 Cost to be allocated (per Wkst. B, Part II)	1,059	0	204.00
205.00 Unit cost multiplier (Wkst. B, Part II)	0.661462	0.000000	205.00
206.00 NAHE adjustment amount to be allocated (per Wkst. B-2)		0	206.00
207.00 NAHE unit cost multiplier (Wkst. D, Parts III and IV)		0.000000	207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0113

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

Worksheet C
Part I
Date/Time Prepared:
5/24/2024 11:54 am

		Title XVIII		Hospital		PPS
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
			Total Costs	RCE Disallowance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS		31,564,123	0	31,564,123	30.00
31.00	03100 INTENSIVE CARE UNIT		10,329,821	0	10,329,821	31.00
43.00	04300 NURSERY		2,917,246	0	2,917,246	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM		24,861,253	0	24,861,253	50.00
51.00	05100 RECOVERY ROOM		0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM		2,217,241	0	2,217,241	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC		4,241,416	0	4,241,416	54.00
54.01	05401 ULTRASOUND		1,231,395	0	1,231,395	54.01
56.00	05600 RADIO SOTOPE		898,971	0	898,971	56.00
57.00	05700 CT SCAN		2,601,237	0	2,601,237	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)		2,516,818	0	2,516,818	58.00
59.00	05900 CARDIAC CATHETERIZATION		2,427,145	0	2,427,145	59.00
60.00	06000 LABORATORY		11,101,201	0	11,101,201	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		1,189,864	0	1,189,864	62.00
64.00	06400 INTRAVENOUS THERAPY		0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0	4,003,610	0	4,003,610	65.00
66.00	06600 PHYSICAL THERAPY	0	6,448,776	0	6,448,776	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	753,356	0	753,356	67.00
68.00	06800 SPEECH PATHOLOGY	0	384,458	0	384,458	68.00
69.00	06900 ELECTROCARDIOLOGY		3,385,836	0	3,385,836	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY		1,606,300	0	1,606,300	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		9,857,231	0	9,857,231	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS		11,670,677	0	11,670,677	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS		15,384,065	0	15,384,065	73.00
74.00	07400 RENAL DIALYSIS		536,736	0	536,736	74.00
77.00	07700 ALLOGENEIC HSCT ACQUISITION		0	0	0	77.00
78.00	07800 CAR T-CELL IMMUNOTHERAPY		0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC		0	0	0	90.00
90.01	09001 WOUND/OSTOMY CLINIC		2,862,221	0	2,862,221	90.01
90.02	09002 CTR ADVANCED HEART CARE		278,027	0	278,027	90.02
90.03	09003 RADIATION ONCOLOGY		5,339,913	0	5,339,913	90.03
90.04	09004 DIABETIC PLUS CLINIC		657,031	0	657,031	90.04
90.05	09005 ANTI COAGULATION CLINIC		616,745	0	616,745	90.05
90.06	09006 MAB 3611 REED		0	0	0	90.06
91.00	09100 EMERGENCY		10,910,097	0	10,910,097	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		2,997,657	0	2,997,657	92.00
OTHER REIMBURSABLE COST CENTERS						
102.00	10200 OPIOID TREATMENT PROGRAM		0	0	0	102.00
200.00	Subtotal (see instructions)		175,790,467	0	175,790,467	200.00
201.00	Less Observation Beds		2,997,657		2,997,657	201.00
202.00	Total (see instructions)		172,792,810	0	172,792,810	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0113

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

Worksheet C
Part I
Date/Time Prepared:
5/24/2024 11:54 am

		Title XVIII			Hospital	PPS	
Cost Center Description		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
		Inpatient	Outpatient	Total (col. 6 + col. 7)			
		6.00	7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	59,713,329		59,713,329		30.00
31.00	03100	INTENSIVE CARE UNIT	20,264,275		20,264,275		31.00
43.00	04300	NURSERY	4,747,590		4,747,590		43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	44,267,911	138,786,437	183,054,348	0.135814	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,353,685	0	4,353,685	0.509279	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,189,585	12,917,740	16,107,325	0.263322	54.00
54.01	05401	ULTRASOUND	1,477,084	9,898,969	11,376,053	0.108244	54.01
56.00	05600	RADIOISOTOPE	574,763	8,739,649	9,314,412	0.096514	56.00
57.00	05700	CT SCAN	12,426,764	45,476,374	57,903,138	0.044924	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	2,407,998	18,854,702	21,262,700	0.118368	58.00
59.00	05900	CARDIAC CATHETERIZATION	11,147,630	21,336,250	32,483,880	0.074718	59.00
60.00	06000	LABORATORY	13,325,231	52,565,907	65,891,138	0.168478	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	2,115,702	883,754	2,999,456	0.396693	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	15,422,423	3,473,399	18,895,822	0.211878	65.00
66.00	06600	PHYSICAL THERAPY	1,298,104	10,347,419	11,645,523	0.553756	66.00
67.00	06700	OCCUPATIONAL THERAPY	907,471	1,124,953	2,032,424	0.370669	67.00
68.00	06800	SPEECH PATHOLOGY	644,275	378,645	1,022,920	0.375844	68.00
69.00	06900	ELECTROCARDIOLOGY	4,519,655	12,488,878	17,008,533	0.199067	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,544,047	5,379,626	6,923,673	0.232001	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	7,746,277	15,025,163	22,771,440	0.432877	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	8,602,520	17,094,533	25,697,053	0.454164	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	21,154,388	38,691,098	59,845,486	0.257063	73.00
74.00	07400	RENAL DIALYSIS	1,535,261	0	1,535,261	0.349606	74.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0.000000	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0.000000	78.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0.000000	90.00
90.01	09001	WOUND/OSTOMY CLINIC	235,705	7,874,428	8,110,133	0.352919	90.01
90.02	09002	CTR ADVANCED HEART CARE	6,713	798,124	804,837	0.345445	90.02
90.03	09003	RADIATION ONCOLOGY	455,329	58,936,771	59,392,100	0.089909	90.03
90.04	09004	DIABETIC PLUS CLINIC	484	306,753	307,237	2.138515	90.04
90.05	09005	ANTI COAGULATION CLINIC	3,233	1,271,579	1,274,812	0.483793	90.05
90.06	09006	MAB 3611 REED	0	0	0	0.000000	90.06
91.00	09100	EMERGENCY	25,698,561	89,828,985	115,527,546	0.094437	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	489,327	3,373,821	3,863,148	0.775962	92.00
OTHER REIMBURSABLE COST CENTERS							
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0		102.00
200.00		Subtotal (see instructions)	270,275,320	575,853,957	846,129,277		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	270,275,320	575,853,957	846,129,277		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0113	Period: From 01/01/2023 To 12/31/2023	Worksheet C Part I Date/Time Prepared: 5/24/2024 11:54 am
		Title XVIII	Hospital	PPS

Cost Center Description		PPS Inpatient Ratio		
		11.00		
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
43.00	04300	NURSERY		43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.135814	50.00
51.00	05100	RECOVERY ROOM	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.509279	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.263322	54.00
54.01	05401	ULTRASOUND	0.108244	54.01
56.00	05600	RADIOISOTOPE	0.096514	56.00
57.00	05700	CT SCAN	0.044924	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.118368	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.074718	59.00
60.00	06000	LABORATORY	0.168478	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.396693	62.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0.211878	65.00
66.00	06600	PHYSICAL THERAPY	0.553756	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.370669	67.00
68.00	06800	SPEECH PATHOLOGY	0.375844	68.00
69.00	06900	ELECTROCARDIOLOGY	0.199067	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.232001	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.432877	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.454164	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.257063	73.00
74.00	07400	RENAL DIALYSIS	0.349606	74.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000	78.00
OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	90.00
90.01	09001	WOUND/OSTOMY CLINIC	0.352919	90.01
90.02	09002	CTR ADVANCED HEART CARE	0.345445	90.02
90.03	09003	RADIATION ONCOLOGY	0.089909	90.03
90.04	09004	DIABETIC PLUS CLINIC	2.138515	90.04
90.05	09005	ANTI COAGULATION CLINIC	0.483793	90.05
90.06	09006	MAB 3611 REED	0.000000	90.06
91.00	09100	EMERGENCY	0.094437	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.775962	92.00
OTHER REIMBURSABLE COST CENTERS				
102.00	10200	OPIOID TREATMENT PROGRAM		102.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0113

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

Worksheet C
Part I
Date/Time Prepared:
5/24/2024 11:54 am

		Title XIX		Hospital		PPS	
Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
				Total Costs	RCE Disallowance		
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	31,564,160		31,564,160	0	31,564,160	30.00
31.00	03100 INTENSIVE CARE UNIT	10,329,821		10,329,821	0	10,329,821	31.00
43.00	04300 NURSERY	2,917,246		2,917,246	0	2,917,246	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	24,921,038		24,921,038	0	24,921,038	50.00
51.00	05100 RECOVERY ROOM	0		0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	2,217,241		2,217,241	0	2,217,241	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	4,241,416		4,241,416	0	4,241,416	54.00
54.01	05401 ULTRASOUND	1,231,395		1,231,395	0	1,231,395	54.01
56.00	05600 RADIOISOTOPE	898,971		898,971	0	898,971	56.00
57.00	05700 CT SCAN	2,601,237		2,601,237	0	2,601,237	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	2,516,818		2,516,818	0	2,516,818	58.00
59.00	05900 CARDIAC CATHETERIZATION	2,427,145		2,427,145	0	2,427,145	59.00
60.00	06000 LABORATORY	11,101,201		11,101,201	0	11,101,201	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	1,189,864		1,189,864	0	1,189,864	62.00
64.00	06400 INTRAVENOUS THERAPY	0		0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	4,003,610	0	4,003,610	0	4,003,610	65.00
66.00	06600 PHYSICAL THERAPY	6,448,776	0	6,448,776	0	6,448,776	66.00
67.00	06700 OCCUPATIONAL THERAPY	753,356	0	753,356	0	753,356	67.00
68.00	06800 SPEECH PATHOLOGY	384,458	0	384,458	0	384,458	68.00
69.00	06900 ELECTROCARDIOLOGY	3,385,836		3,385,836	0	3,385,836	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	1,606,300		1,606,300	0	1,606,300	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	9,857,231		9,857,231	0	9,857,231	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	11,670,677		11,670,677	0	11,670,677	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	15,384,065		15,384,065	0	15,384,065	73.00
74.00	07400 RENAL DIALYSIS	536,736		536,736	0	536,736	74.00
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0		0	0	0	77.00
78.00	07800 CAR T-CELL IMMUNOTHERAPY	0		0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0		0	0	0	90.00
90.01	09001 WOUND/OSTOMY CLINIC	2,862,221		2,862,221	0	2,862,221	90.01
90.02	09002 CTR ADVANCED HEART CARE	278,027		278,027	0	278,027	90.02
90.03	09003 RADIATION ONCOLOGY	5,339,913		5,339,913	0	5,339,913	90.03
90.04	09004 DIABETIC PLUS CLINIC	657,031		657,031	0	657,031	90.04
90.05	09005 ANTI COAGULATION CLINIC	616,745		616,745	0	616,745	90.05
90.06	09006 MAB 3611 REED	0		0	0	0	90.06
91.00	09100 EMERGENCY	10,910,097		10,910,097	0	10,910,097	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	2,997,657		2,997,657	0	2,997,657	92.00
OTHER REIMBURSABLE COST CENTERS							
102.00	10200 OPIOID TREATMENT PROGRAM	0		0	0	0	102.00
200.00	Subtotal (see instructions)	175,850,289	0	175,850,289	0	175,850,289	200.00
201.00	Less Observation Beds	2,997,657		2,997,657		2,997,657	201.00
202.00	Total (see instructions)	172,852,632	0	172,852,632	0	172,852,632	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 15-0113		Period: From 01/01/2023 To 12/31/2023		Worksheet C Part I Date/Time Prepared: 5/24/2024 11:54 am		
			Title XIX			Hospital		PPS	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
			Inpatient	Outpatient	Total (col. 6 + col. 7)				
			6.00	7.00	8.00	9.00	10.00		
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	59,713,329		59,713,329				30.00
31.00	03100	INTENSIVE CARE UNIT	20,264,275		20,264,275				31.00
43.00	04300	NURSERY	4,747,590		4,747,590				43.00
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	44,267,911	138,786,437	183,054,348	0.136140	0.000000		50.00
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	0.000000		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,353,685	0	4,353,685	0.509279	0.000000		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,189,585	12,917,740	16,107,325	0.263322	0.000000		54.00
54.01	05401	ULTRASOUND	1,477,084	9,898,969	11,376,053	0.108244	0.000000		54.01
56.00	05600	RADIOISOTOPE	574,763	8,739,649	9,314,412	0.096514	0.000000		56.00
57.00	05700	CT SCAN	12,426,764	45,476,374	57,903,138	0.044924	0.000000		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	2,407,998	18,854,702	21,262,700	0.118368	0.000000		58.00
59.00	05900	CARDIAC CATHETERIZATION	11,147,630	21,336,250	32,483,880	0.074718	0.000000		59.00
60.00	06000	LABORATORY	13,325,231	52,565,907	65,891,138	0.168478	0.000000		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	2,115,702	883,754	2,999,456	0.396693	0.000000		62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0.000000	0.000000		64.00
65.00	06500	RESPIRATORY THERAPY	15,422,423	3,473,399	18,895,822	0.211878	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	1,298,104	10,347,419	11,645,523	0.553756	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	907,471	1,124,953	2,032,424	0.370669	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	644,275	378,645	1,022,920	0.375844	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	4,519,655	12,488,878	17,008,533	0.199067	0.000000		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,544,047	5,379,626	6,923,673	0.232001	0.000000		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	7,746,277	15,025,163	22,771,440	0.432877	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	8,602,520	17,094,533	25,697,053	0.454164	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	21,154,388	38,691,098	59,845,486	0.257063	0.000000		73.00
74.00	07400	RENAL DIALYSIS	1,535,261	0	1,535,261	0.349606	0.000000		74.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0.000000	0.000000		77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0.000000	0.000000		78.00
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	0	0	0	0.000000	0.000000		90.00
90.01	09001	WOUND/OSTOMY CLINIC	235,705	7,874,428	8,110,133	0.352919	0.000000		90.01
90.02	09002	CTR ADVANCED HEART CARE	6,713	798,124	804,837	0.345445	0.000000		90.02
90.03	09003	RADIATION ONCOLOGY	455,329	58,936,771	59,392,100	0.089909	0.000000		90.03
90.04	09004	DIABETIC PLUS CLINIC	484	306,753	307,237	2.138515	0.000000		90.04
90.05	09005	ANTI COAGULATION CLINIC	3,233	1,271,579	1,274,812	0.483793	0.000000		90.05
90.06	09006	MAB 3611 REED	0	0	0	0.000000	0.000000		90.06
91.00	09100	EMERGENCY	25,698,561	89,828,985	115,527,546	0.094437	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	489,327	3,373,821	3,863,148	0.775962	0.000000		92.00
OTHER REIMBURSABLE COST CENTERS									
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0				102.00
200.00		Subtotal (see instructions)	270,275,320	575,853,957	846,129,277				200.00
201.00		Less Observation Beds							201.00
202.00		Total (see instructions)	270,275,320	575,853,957	846,129,277				202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0113	Period: From 01/01/2023 To 12/31/2023	Worksheet C Part I Date/Time Prepared: 5/24/2024 11:54 am
		Title XIX	Hospital	PPS

Cost Center Description		PPS Inpatient Ratio		
		11.00		
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
43.00	04300 NURSERY			43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.136140		50.00
51.00	05100 RECOVERY ROOM	0.000000		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.509279		52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.263322		54.00
54.01	05401 ULTRASOUND	0.108244		54.01
56.00	05600 RADIOISOTOPE	0.096514		56.00
57.00	05700 CT SCAN	0.044924		57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.118368		58.00
59.00	05900 CARDIAC CATHETERIZATION	0.074718		59.00
60.00	06000 LABORATORY	0.168478		60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.396693		62.00
64.00	06400 INTRAVENOUS THERAPY	0.000000		64.00
65.00	06500 RESPIRATORY THERAPY	0.211878		65.00
66.00	06600 PHYSICAL THERAPY	0.553756		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.370669		67.00
68.00	06800 SPEECH PATHOLOGY	0.375844		68.00
69.00	06900 ELECTROCARDIOLOGY	0.199067		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.232001		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.432877		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.454164		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.257063		73.00
74.00	07400 RENAL DIALYSIS	0.349606		74.00
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0.000000		77.00
78.00	07800 CAR T-CELL IMMUNOTHERAPY	0.000000		78.00
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0.000000		90.00
90.01	09001 WOUND/OSTOMY CLINIC	0.352919		90.01
90.02	09002 CTR ADVANCED HEART CARE	0.345445		90.02
90.03	09003 RADIATION ONCOLOGY	0.089909		90.03
90.04	09004 DIABETIC PLUS CLINIC	2.138515		90.04
90.05	09005 ANTI COAGULATION CLINIC	0.483793		90.05
90.06	09006 MAB 3611 REED	0.000000		90.06
91.00	09100 EMERGENCY	0.094437		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.775962		92.00
OTHER REIMBURSABLE COST CENTERS				
102.00	10200 OPIOID TREATMENT PROGRAM			102.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

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

Provider CCN: 15-0113

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

Worksheet C Part II Date/Time Prepared: 5/24/2024 11:54 am

Cost Center Description			Title XIX			Hospital	PPS	
			Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
			1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	24,921,038	2,852,764	22,068,274	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,217,241	142,616	2,074,625	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,241,416	454,369	3,787,047	0	0	54.00
54.01	05401	ULTRASOUND	1,231,395	54,244	1,177,151	0	0	54.01
56.00	05600	RADIOISOTOPE	898,971	101,454	797,517	0	0	56.00
57.00	05700	CT SCAN	2,601,237	189,874	2,411,363	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	2,516,818	528,021	1,988,797	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	2,427,145	333,262	2,093,883	0	0	59.00
60.00	06000	LABORATORY	11,101,201	703,573	10,397,628	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	1,189,864	50,820	1,139,044	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	4,003,610	176,335	3,827,275	0	0	65.00
66.00	06600	PHYSICAL THERAPY	6,448,776	1,154,405	5,294,371	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	753,356	41,062	712,294	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	384,458	20,791	363,667	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	3,385,836	435,318	2,950,518	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,606,300	124,906	1,481,394	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	9,857,231	301,332	9,555,899	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	11,670,677	356,708	11,313,969	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	15,384,065	761,088	14,622,977	0	0	73.00
74.00	07400	RENAL DIALYSIS	536,736	13,668	523,068	0	0	74.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND/OSTOMY CLINIC	2,862,221	167,296	2,694,925	0	0	90.01
90.02	09002	CTR ADVANCED HEART CARE	278,027	8,761	269,266	0	0	90.02
90.03	09003	RADIATION ONCOLOGY	5,339,913	613,242	4,726,671	0	0	90.03
90.04	09004	DIABETIC PLUS CLINIC	657,031	20,313	636,718	0	0	90.04
90.05	09005	ANTI COAGULATION CLINIC	616,745	16,998	599,747	0	0	90.05
90.06	09006	MAB 3611 REED	0	0	0	0	0	90.06
91.00	09100	EMERGENCY	10,910,097	541,550	10,368,547	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,997,657	157,530	2,840,127	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
200.00		Subtotal (sum of lines 50 thru 199)	131,039,062	10,322,300	120,716,762	0	0	200.00
201.00		Less Observation Beds	2,997,657	157,530	2,840,127	0	0	201.00
202.00		Total (line 200 minus line 201)	128,041,405	10,164,770	117,876,635	0	0	202.00

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY		Provider CCN: 15-0113	Period: From 01/01/2023 To 12/31/2023	Worksheet C Part II Date/Time Prepared: 5/24/2024 11:54 am
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Cost Center Description		Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)	Hospital	PPS
		6.00	7.00	8.00		
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	24,921,038	183,054,348	0.136140		50.00
51.00	05100 RECOVERY ROOM	0	0	0.000000		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	2,217,241	4,353,685	0.509279		52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	4,241,416	16,107,325	0.263322		54.00
54.01	05401 ULTRASOUND	1,231,395	11,376,053	0.108244		54.01
56.00	05600 RADIOISOTOPE	898,971	9,314,412	0.096514		56.00
57.00	05700 CT SCAN	2,601,237	57,903,138	0.044924		57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	2,516,818	21,262,700	0.118368		58.00
59.00	05900 CARDIAC CATHETERIZATION	2,427,145	32,483,880	0.074718		59.00
60.00	06000 LABORATORY	11,101,201	65,891,138	0.168478		60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	1,189,864	2,999,456	0.396693		62.00
64.00	06400 INTRAVENOUS THERAPY	0	0	0.000000		64.00
65.00	06500 RESPIRATORY THERAPY	4,003,610	18,895,822	0.211878		65.00
66.00	06600 PHYSICAL THERAPY	6,448,776	11,645,523	0.553756		66.00
67.00	06700 OCCUPATIONAL THERAPY	753,356	2,032,424	0.370669		67.00
68.00	06800 SPEECH PATHOLOGY	384,458	1,022,920	0.375844		68.00
69.00	06900 ELECTROCARDIOLOGY	3,385,836	17,008,533	0.199067		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	1,606,300	6,923,673	0.232001		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	9,857,231	22,771,440	0.432877		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	11,670,677	25,697,053	0.454164		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	15,384,065	59,845,486	0.257063		73.00
74.00	07400 RENAL DIALYSIS	536,736	1,535,261	0.349606		74.00
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0	0	0.000000		77.00
78.00	07800 CAR T-CELL IMMUNOTHERAPY	0	0	0.000000		78.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	0	0	0.000000		90.00
90.01	09001 WOUND/OSTOMY CLINIC	2,862,221	8,110,133	0.352919		90.01
90.02	09002 CTR ADVANCED HEART CARE	278,027	804,837	0.345445		90.02
90.03	09003 RADIATION ONCOLOGY	5,339,913	59,392,100	0.089909		90.03
90.04	09004 DIABETIC PLUS CLINIC	657,031	307,237	2.138515		90.04
90.05	09005 ANTI COAGULATION CLINIC	616,745	1,274,812	0.483793		90.05
90.06	09006 MAB 3611 REED	0	0	0.000000		90.06
91.00	09100 EMERGENCY	10,910,097	115,527,546	0.094437		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	2,997,657	3,863,148	0.775962		92.00
OTHER REIMBURSABLE COST CENTERS						
102.00	10200 OPIOID TREATMENT PROGRAM	0	0	0.000000		102.00
200.00	Subtotal (sum of lines 50 thru 199)	131,039,062	761,404,083			200.00
201.00	Less Observation Beds	2,997,657	0			201.00
202.00	Total (line 200 minus line 201)	128,041,405	761,404,083			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 15-0113		Period: From 01/01/2023 To 12/31/2023		Worksheet D Part I Date/Time Prepared: 5/24/2024 11:54 am		
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)		
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	4.00	5.00		
30.00	ADULTS & PEDIATRICS	1,658,719	0	1,658,719	21,175	78.33	30.00	
31.00	INTENSIVE CARE UNIT	583,998		583,998	4,135	141.23	31.00	
43.00	NURSERY	246,042		246,042	921	267.15	43.00	
200.00	Total (lines 30 through 199)	2,488,759		2,488,759	26,231		200.00	
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)					
INPATIENT ROUTINE SERVICE COST CENTERS		6.00	7.00					
30.00	ADULTS & PEDIATRICS	4,710	368,934					30.00
31.00	INTENSIVE CARE UNIT	1,168	164,957					31.00
43.00	NURSERY	0	0					43.00
200.00	Total (lines 30 through 199)	5,878	533,891					200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 15-0113	Period: From 01/01/2023 To 12/31/2023	Worksheet D Part II Date/Time Prepared: 5/24/2024 11:54 am
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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)	Hospital Inpatient Program Charges	Capital Costs (column 3 x column 4)	PPS
			1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,852,764	183,054,348	0.015584	10,414,470	162,299	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	142,616	4,353,685	0.032758	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	454,369	16,107,325	0.028209	880,054	24,825	54.00
54.01	05401	ULTRASOUND	54,244	11,376,053	0.004768	361,061	1,722	54.01
56.00	05600	RADIOISOTOPE	101,454	9,314,412	0.010892	159,149	1,733	56.00
57.00	05700	CT SCAN	189,874	57,903,138	0.003279	3,359,981	11,017	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	528,021	21,262,700	0.024833	647,963	16,091	58.00
59.00	05900	CARDIAC CATHETERIZATION	333,262	32,483,880	0.010259	2,492,281	25,568	59.00
60.00	06000	LABORATORY	703,573	65,891,138	0.010678	3,526,703	37,658	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	50,820	2,999,456	0.016943	543,526	9,209	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0.000000	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	176,335	18,895,822	0.009332	3,905,063	36,442	65.00
66.00	06600	PHYSICAL THERAPY	1,154,405	11,645,523	0.099129	416,568	41,294	66.00
67.00	06700	OCCUPATIONAL THERAPY	41,062	2,032,424	0.020203	286,387	5,786	67.00
68.00	06800	SPEECH PATHOLOGY	20,791	1,022,920	0.020325	208,644	4,241	68.00
69.00	06900	ELECTROCARDIOLOGY	435,318	17,008,533	0.025594	1,242,638	31,804	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	124,906	6,923,673	0.018040	278,877	5,031	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	301,332	22,771,440	0.013233	1,925,299	25,477	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	356,708	25,697,053	0.013881	2,337,037	32,440	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	761,088	59,845,486	0.012718	6,045,447	76,886	73.00
74.00	07400	RENAL DIALYSIS	13,668	1,535,261	0.008903	414,197	3,688	74.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0.000000	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0.000000	0	0	78.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
90.01	09001	WOUND/OSTOMY CLINIC	167,296	8,110,133	0.020628	58,746	1,212	90.01
90.02	09002	CTR ADVANCED HEART CARE	8,761	804,837	0.010885	0	0	90.02
90.03	09003	RADIATION ONCOLOGY	613,242	59,392,100	0.010325	206,246	2,129	90.03
90.04	09004	DIABETIC PLUS CLINIC	20,313	307,237	0.066115	0	0	90.04
90.05	09005	ANTI COAGULATION CLINIC	16,998	1,274,812	0.013334	0	0	90.05
90.06	09006	MAB 3611 REED	0	0	0.000000	0	0	90.06
91.00	09100	EMERGENCY	541,550	115,527,546	0.004688	6,822,989	31,986	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	157,530	3,863,148	0.040778	208,597	8,506	92.00
200.00		Total (lines 50 through 199)	10,322,300	761,404,083		46,741,923	597,044	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0113	Period: From 01/01/2023 To 12/31/2023	Worksheet D Part III Date/Time Prepared: 5/24/2024 11:54 am
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Cost Center Description			Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost		
			1A	1.00	2A	2.00	3.00		
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00	
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00	
43.00	04300	NURSERY	0	0	0	0	0	43.00	
200.00		Total (lines 30 through 199)	0	0	0	0	0	200.00	
Cost Center Description			Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 + col. 6)	Inpatient Program Days		
			4.00	5.00	6.00	7.00	8.00		
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	0	0	21,175	0.00	4,710	30.00	
31.00	03100	INTENSIVE CARE UNIT		0	4,135	0.00	1,168	31.00	
43.00	04300	NURSERY		0	921	0.00	0	43.00	
200.00		Total (lines 30 through 199)		0	26,231		5,878	200.00	
Cost Center Description			Inpatient Program Pass-Through Cost (col. 7 x col. 8)						
			9.00						
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	0						30.00
31.00	03100	INTENSIVE CARE UNIT	0						31.00
43.00	04300	NURSERY	0						43.00
200.00		Total (lines 30 through 199)	0						200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0113

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

Worksheet D
Part IV
Date/Time Prepared:
5/24/2024 11:54 am

Cost Center Description		Title XVIII			Hospital		PPS	
		Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health		
		1.00	2A	2.00	3A	3.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
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	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND/OSTOMY CLINIC	0	0	0	0	0	90.01
90.02	09002	CTR ADVANCED HEART CARE	0	0	0	0	0	90.02
90.03	09003	RADIATION ONCOLOGY	0	0	0	0	0	90.03
90.04	09004	DIABETIC PLUS CLINIC	0	0	0	0	0	90.04
90.05	09005	ANTI COAGULATION CLINIC	0	0	0	0	0	90.05
90.06	09006	MAB 3611 REED	0	0	0	0	0	90.06
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0113

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

Worksheet D
Part IV
Date/Time Prepared:
5/24/2024 11:54 am

Cost Center Description		Title XVIII			Hospital	PPS		
		All Other Medical Education Cost	Total Cost (sum of col. 1, 2, 3, and 4)	Total Outpatient Cost (sum of col. 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	183,054,348	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	4,353,685	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	16,107,325	0.000000	54.00
54.01	05401	ULTRASOUND	0	0	0	11,376,053	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0	9,314,412	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	57,903,138	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	21,262,700	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	32,483,880	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	65,891,138	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	2,999,456	0.000000	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	18,895,822	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	11,645,523	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	2,032,424	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	1,022,920	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	17,008,533	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	6,923,673	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	22,771,440	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	25,697,053	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	59,845,486	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	1,535,261	0.000000	74.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0.000000	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0.000000	78.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0.000000	90.00
90.01	09001	WOUND/OSTOMY CLINIC	0	0	0	8,110,133	0.000000	90.01
90.02	09002	CTR ADVANCED HEART CARE	0	0	0	804,837	0.000000	90.02
90.03	09003	RADIATION ONCOLOGY	0	0	0	59,392,100	0.000000	90.03
90.04	09004	DIABETIC PLUS CLINIC	0	0	0	307,237	0.000000	90.04
90.05	09005	ANTICOAGULATION CLINIC	0	0	0	1,274,812	0.000000	90.05
90.06	09006	MAB 3611 REED	0	0	0	0	0.000000	90.06
91.00	09100	EMERGENCY	0	0	0	115,527,546	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	3,863,148	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	761,404,083		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0113	Period: From 01/01/2023 To 12/31/2023	Worksheet D Part IV Date/Time Prepared: 5/24/2024 11:54 am
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Cost Center Description			Title XVIII			Hospital		PPS	
			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	10,414,470	0	22,253,965	0	50.00	
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	880,054	0	1,932,245	0	54.00	
54.01	05401	ULTRASOUND	0.000000	361,061	0	1,621,335	0	54.01	
56.00	05600	RADIOISOTOPE	0.000000	159,149	0	2,017,336	0	56.00	
57.00	05700	CT SCAN	0.000000	3,359,981	0	9,298,963	0	57.00	
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	647,963	0	3,847,904	0	58.00	
59.00	05900	CARDIAC CATHETERIZATION	0.000000	2,492,281	0	5,232,425	0	59.00	
60.00	06000	LABORATORY	0.000000	3,526,703	0	3,226,550	0	60.00	
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	543,526	0	241,308	0	62.00	
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00	
65.00	06500	RESPIRATORY THERAPY	0.000000	3,905,063	0	526,514	0	65.00	
66.00	06600	PHYSICAL THERAPY	0.000000	416,568	0	23,238	0	66.00	
67.00	06700	OCCUPATIONAL THERAPY	0.000000	286,387	0	9,088	0	67.00	
68.00	06800	SPEECH PATHOLOGY	0.000000	208,644	0	4,183	0	68.00	
69.00	06900	ELECTROCARDIOLOGY	0.000000	1,242,638	0	2,878,586	0	69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	278,877	0	606,750	0	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	1,925,299	0	2,586,514	0	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	2,337,037	0	2,689,800	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	6,045,447	0	10,545,683	0	73.00	
74.00	07400	RENAL DIALYSIS	0.000000	414,197	0	0	0	74.00	
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	0	0	77.00	
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000	0	0	0	0	78.00	
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00	
90.01	09001	WOUND/OSTOMY CLINIC	0.000000	58,746	0	2,312,232	0	90.01	
90.02	09002	CTR ADVANCED HEART CARE	0.000000	0	0	208,547	0	90.02	
90.03	09003	RADIATION ONCOLOGY	0.000000	206,246	0	13,072,785	0	90.03	
90.04	09004	DIABETIC PLUS CLINIC	0.000000	0	0	0	0	90.04	
90.05	09005	ANTI COAGULATION CLINIC	0.000000	0	0	350,358	0	90.05	
90.06	09006	MAB 3611 REED	0.000000	0	0	0	0	90.06	
91.00	09100	EMERGENCY	0.000000	6,822,989	0	12,095,193	0	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	208,597	0	280,532	0	92.00	
200.00		Total (lines 50 through 199)		46,741,923	0	97,862,034	0	200.00	

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 15-0113	Period: From 01/01/2023 To 12/31/2023	Worksheet D Part V Date/Time Prepared: 5/24/2024 11:54 am
		Title XVIII	Hospital	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs			
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)			
	1.00	2.00	3.00	4.00	5.00			
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.135814	22,253,965	0	0	3,022,400	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.509279	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.263322	1,932,245	0	0	508,803	54.00
54.01	05401	ULTRASOUND	0.108244	1,621,335	0	0	175,500	54.01
56.00	05600	RADIOISOTOPE	0.096514	2,017,336	0	0	194,701	56.00
57.00	05700	CT SCAN	0.044924	9,298,963	0	0	417,747	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.118368	3,847,904	0	0	455,469	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.074718	5,232,425	0	0	390,956	59.00
60.00	06000	LABORATORY	0.168478	3,226,550	15,180	0	543,603	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.396693	241,308	0	0	95,725	62.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.211878	526,514	0	0	111,557	65.00
66.00	06600	PHYSICAL THERAPY	0.553756	23,238	0	0	12,868	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.370669	9,088	0	0	3,369	67.00
68.00	06800	SPEECH PATHOLOGY	0.375844	4,183	0	0	1,572	68.00
69.00	06900	ELECTROCARDIOLOGY	0.199067	2,878,586	0	0	573,031	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.232001	606,750	0	0	140,767	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.432877	2,586,514	2,489	0	1,119,642	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.454164	2,689,800	0	0	1,221,610	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.257063	10,545,683	0	8,864	2,710,905	73.00
74.00	07400	RENAL DIALYSIS	0.349606	0	0	0	0	74.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000	0	0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	WOUND/OSTOMY CLINIC	0.352919	2,312,232	0	0	816,031	90.01
90.02	09002	CTR ADVANCED HEART CARE	0.345445	208,547	0	0	72,042	90.02
90.03	09003	RADIATION ONCOLOGY	0.089909	13,072,785	0	0	1,175,361	90.03
90.04	09004	DIABETIC PLUS CLINIC	2.138515	0	0	0	0	90.04
90.05	09005	ANTI COAGULATION CLINIC	0.483793	350,358	0	0	169,501	90.05
90.06	09006	MAB 3611 REED	0.000000	0	0	0	0	90.06
91.00	09100	EMERGENCY	0.094437	12,095,193	0	0	1,142,234	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.775962	280,532	0	0	217,682	92.00
200.00		Subtotal (see instructions)		97,862,034	17,669	8,864	15,293,076	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0	0	201.00
202.00		Net Charges (line 200 - line 201)		97,862,034	17,669	8,864	15,293,076	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 15-0113	Period: From 01/01/2023 To 12/31/2023	Worksheet D Part V Date/Time Prepared: 5/24/2024 11:54 am
		Title XVIII	Hospital	PPS

Cost Center Description	Costs				
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)			
	6.00	7.00			
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
54.01	05401	ULTRASOUND	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	56.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	2,557	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
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	1,077	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,279	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	78.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	90.00
90.01	09001	WOUND/OSTOMY CLINIC	0	0	90.01
90.02	09002	CTR ADVANCED HEART CARE	0	0	90.02
90.03	09003	RADIATION ONCOLOGY	0	0	90.03
90.04	09004	DIABETIC PLUS CLINIC	0	0	90.04
90.05	09005	ANTI COAGULATION CLINIC	0	0	90.05
90.06	09006	MAB 3611 REED	0	0	90.06
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
200.00		Subtotal (see instructions)	3,634	2,279	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	3,634	2,279	202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 15-0113	Period: From 01/01/2023 To 12/31/2023	Worksheet D Part I Date/Time Prepared: 5/24/2024 11:54 am
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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	
Title XIX Hospital PPS							
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	1,658,719	0	1,658,719	21,175	78.33	30.00
31.00	INTENSIVE CARE UNIT	583,998		583,998	4,135	141.23	31.00
43.00	NURSERY	246,042		246,042	921	267.15	43.00
200.00	Total (lines 30 through 199)	2,488,759		2,488,759	26,231		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	677	53,029				
31.00	INTENSIVE CARE UNIT	320	45,194				
43.00	NURSERY	727	194,218				
200.00	Total (lines 30 through 199)	1,724	292,441				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 15-0113	Period: From 01/01/2023 To 12/31/2023	Worksheet D Part II Date/Time Prepared: 5/24/2024 11:54 am
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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	
Title XIX								
Hospital								
PPS								
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,852,764	183,054,348	0.015584	1,073,946	16,736	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	142,616	4,353,685	0.032758	199,831	6,546	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	454,369	16,107,325	0.028209	102,180	2,882	54.00
54.01	05401	ULTRASOUND	54,244	11,376,053	0.004768	107,005	510	54.01
56.00	05600	RADIOISOTOPE	101,454	9,314,412	0.010892	7,005	76	56.00
57.00	05700	CT SCAN	189,874	57,903,138	0.003279	382,328	1,254	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	528,021	21,262,700	0.024833	84,485	2,098	58.00
59.00	05900	CARDIAC CATHETERIZATION	333,262	32,483,880	0.010259	63,949	656	59.00
60.00	06000	LABORATORY	703,573	65,891,138	0.010678	544,013	5,809	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	50,820	2,999,456	0.016943	91,604	1,552	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0.000000	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	176,335	18,895,822	0.009332	709,637	6,622	65.00
66.00	06600	PHYSICAL THERAPY	1,154,405	11,645,523	0.099129	37,099	3,678	66.00
67.00	06700	OCCUPATIONAL THERAPY	41,062	2,032,424	0.020203	29,570	597	67.00
68.00	06800	SPEECH PATHOLOGY	20,791	1,022,920	0.020325	24,457	497	68.00
69.00	06900	ELECTROCARDIOLOGY	435,318	17,008,533	0.025594	116,268	2,976	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	124,906	6,923,673	0.018040	38,485	694	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	301,332	22,771,440	0.013233	302,623	4,005	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	356,708	25,697,053	0.013881	142,923	1,984	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	761,088	59,845,486	0.012718	1,021,063	12,986	73.00
74.00	07400	RENAL DIALYSIS	13,668	1,535,261	0.008903	67,749	603	74.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0.000000	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0.000000	0	0	78.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
90.01	09001	WOUND/OSTOMY CLINIC	167,296	8,110,133	0.020628	10,324	213	90.01
90.02	09002	CTR ADVANCED HEART CARE	8,761	804,837	0.010885	269	3	90.02
90.03	09003	RADIATION ONCOLOGY	613,242	59,392,100	0.010325	899	9	90.03
90.04	09004	DIABETIC PLUS CLINIC	20,313	307,237	0.066115	0	0	90.04
90.05	09005	ANTI COAGULATION CLINIC	16,998	1,274,812	0.013334	0	0	90.05
90.06	09006	MAB 3611 REED	0	0	0.000000	0	0	90.06
91.00	09100	EMERGENCY	541,550	115,527,546	0.004688	885,882	4,153	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	157,530	3,863,148	0.040778	2,930	119	92.00
200.00		Total (lines 50 through 199)	10,322,300	761,404,083		6,046,524	77,258	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0113	Period: From 01/01/2023 To 12/31/2023	Worksheet D Part III Date/Time Prepared: 5/24/2024 11:54 am
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Cost Center Description			Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost		
			1A	1.00	2A	2.00	3.00		
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00	
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00	
43.00	04300	NURSERY	0	0	0	0	0	43.00	
200.00		Total (lines 30 through 199)	0	0	0	0	0	200.00	
Cost Center Description			Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 + col. 6)	Inpatient Program Days		
			4.00	5.00	6.00	7.00	8.00		
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	0	0	21,175	0.00	677	30.00	
31.00	03100	INTENSIVE CARE UNIT		0	4,135	0.00	320	31.00	
43.00	04300	NURSERY		0	921	0.00	727	43.00	
200.00		Total (lines 30 through 199)		0	26,231		1,724	200.00	
Cost Center Description			Inpatient Program Pass-Through Cost (col. 7 x col. 8)						
			9.00						
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	0						30.00
31.00	03100	INTENSIVE CARE UNIT	0						31.00
43.00	04300	NURSERY	0						43.00
200.00		Total (lines 30 through 199)	0						200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0113

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

Worksheet D
Part IV
Date/Time Prepared:
5/24/2024 11:54 am

Cost Center Description		Title XIX			Hospital		PPS	
		Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health		
		1.00	2A	2.00	3A	3.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
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	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND/OSTOMY CLINIC	0	0	0	0	0	90.01
90.02	09002	CTR ADVANCED HEART CARE	0	0	0	0	0	90.02
90.03	09003	RADIATION ONCOLOGY	0	0	0	0	0	90.03
90.04	09004	DIABETIC PLUS CLINIC	0	0	0	0	0	90.04
90.05	09005	ANTI COAGULATION CLINIC	0	0	0	0	0	90.05
90.06	09006	MAB 3611 REED	0	0	0	0	0	90.06
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0113

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

Worksheet D
Part IV
Date/Time Prepared:
5/24/2024 11:54 am

Cost Center Description		Title XIX			Hospital	PPS		
		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	183,054,348	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	4,353,685	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	16,107,325	0.000000	54.00
54.01	05401	ULTRASOUND	0	0	0	11,376,053	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0	9,314,412	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	57,903,138	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	21,262,700	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	32,483,880	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	65,891,138	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	2,999,456	0.000000	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	18,895,822	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	11,645,523	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	2,032,424	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	1,022,920	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	17,008,533	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	6,923,673	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	22,771,440	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	25,697,053	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	59,845,486	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	1,535,261	0.000000	74.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0.000000	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0.000000	78.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0.000000	90.00
90.01	09001	WOUND/OSTOMY CLINIC	0	0	0	8,110,133	0.000000	90.01
90.02	09002	CTR ADVANCED HEART CARE	0	0	0	804,837	0.000000	90.02
90.03	09003	RADIATION ONCOLOGY	0	0	0	59,392,100	0.000000	90.03
90.04	09004	DIABETIC PLUS CLINIC	0	0	0	307,237	0.000000	90.04
90.05	09005	ANTICOAGULATION CLINIC	0	0	0	1,274,812	0.000000	90.05
90.06	09006	MAB 3611 REED	0	0	0	0	0.000000	90.06
91.00	09100	EMERGENCY	0	0	0	115,527,546	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	3,863,148	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	761,404,083		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0113

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

Worksheet D
Part IV
Date/Time Prepared:
5/24/2024 11:54 am

Cost Center Description		Title XIX			Hospital		PPS
		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	1,073,946	0	0	0	50.00
51.00	05100 RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	199,831	0	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000	102,180	0	0	0	54.00
54.01	05401 ULTRASOUND	0.000000	107,005	0	0	0	54.01
56.00	05600 RADIOISOTOPE	0.000000	7,005	0	0	0	56.00
57.00	05700 CT SCAN	0.000000	382,328	0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	84,485	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	63,949	0	0	0	59.00
60.00	06000 LABORATORY	0.000000	544,013	0	0	0	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	91,604	0	0	0	62.00
64.00	06400 INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.000000	709,637	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.000000	37,099	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	29,570	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	24,457	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	116,268	0	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	38,485	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	302,623	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	142,923	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000	1,021,063	0	0	0	73.00
74.00	07400 RENAL DIALYSIS	0.000000	67,749	0	0	0	74.00
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	0	0	77.00
78.00	07800 CAR T-CELL IMMUNOTHERAPY	0.000000	0	0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0.000000	0	0	0	0	90.00
90.01	09001 WOUND/OSTOMY CLINIC	0.000000	10,324	0	0	0	90.01
90.02	09002 CTR ADVANCED HEART CARE	0.000000	269	0	0	0	90.02
90.03	09003 RADIATION ONCOLOGY	0.000000	899	0	0	0	90.03
90.04	09004 DIABETIC PLUS CLINIC	0.000000	0	0	0	0	90.04
90.05	09005 ANTI COAGULATION CLINIC	0.000000	0	0	0	0	90.05
90.06	09006 MAB 3611 REED	0.000000	0	0	0	0	90.06
91.00	09100 EMERGENCY	0.000000	885,882	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	2,930	0	0	0	92.00
200.00	Total (lines 50 through 199)		6,046,524	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 15-0113	Period: From 01/01/2023 To 12/31/2023	Worksheet D Part V Date/Time Prepared: 5/24/2024 11:54 am
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		Title XIX		Hospital		PPS		
Cost Center Description		Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs		PPS Services (see inst.)	
			PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)			
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.136140	0	1,888,925	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.509279	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.263322	0	276,598	0	0	54.00
54.01	05401	ULTRASOUND	0.108244	0	233,346	0	0	54.01
56.00	05600	RADIOISOTOPE	0.096514	0	66,243	0	0	56.00
57.00	05700	CT SCAN	0.044924	0	1,007,919	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.118368	0	279,426	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.074718	0	105,408	0	0	59.00
60.00	06000	LABORATORY	0.168478	0	956,462	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.396693	0	19,486	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.211878	0	29,134	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.553756	0	126,742	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.370669	0	13,486	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.375844	0	5,734	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.199067	0	127,671	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.232001	0	134,087	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.432877	0	441,412	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.454164	0	230,145	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.257063	0	275,193	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.349606	0	0	0	0	74.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000	0	0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	WOUND/OSTOMY CLINIC	0.352919	0	309,358	0	0	90.01
90.02	09002	CTR ADVANCED HEART CARE	0.345445	0	12,665	0	0	90.02
90.03	09003	RADIATION ONCOLOGY	0.089909	0	1,741,599	0	0	90.03
90.04	09004	DIABETIC PLUS CLINIC	2.138515	0	4,418	0	0	90.04
90.05	09005	ANTI COAGULATION CLINIC	0.483793	0	8,914	0	0	90.05
90.06	09006	MAB 3611 REED	0.000000	0	0	0	0	90.06
91.00	09100	EMERGENCY	0.094437	0	3,434,533	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.775962	0	44,258	0	0	92.00
200.00		Subtotal (see instructions)		0	11,773,162	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0	0	201.00
202.00		Net Charges (line 200 - line 201)		0	11,773,162	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 15-0113	Period: From 01/01/2023 To 12/31/2023	Worksheet D Part V Date/Time Prepared: 5/24/2024 11:54 am
		Title XIX	Hospital	PPS

Cost Center Description	Costs			
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
ANCILLARY SERVICE COST CENTERS				
50.00 05000	OPERATING ROOM	257,158	0	50.00
51.00 05100	RECOVERY ROOM	0	0	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	72,834	0	54.00
54.01 05401	ULTRASOUND	25,258	0	54.01
56.00 05600	RADIOISOTOPE	6,393	0	56.00
57.00 05700	CT SCAN	45,280	0	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	33,075	0	58.00
59.00 05900	CARDIAC CATHETERIZATION	7,876	0	59.00
60.00 06000	LABORATORY	161,143	0	60.00
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	7,730	0	62.00
64.00 06400	INTRAVENOUS THERAPY	0	0	64.00
65.00 06500	RESPIRATORY THERAPY	6,173	0	65.00
66.00 06600	PHYSICAL THERAPY	70,184	0	66.00
67.00 06700	OCCUPATIONAL THERAPY	4,999	0	67.00
68.00 06800	SPEECH PATHOLOGY	2,155	0	68.00
69.00 06900	ELECTROCARDIOLOGY	25,415	0	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	31,108	0	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	191,077	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	104,524	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	70,742	0	73.00
74.00 07400	RENAL DIALYSIS	0	0	74.00
77.00 07700	ALLOGENEIC HSCT ACQUISITION	0	0	77.00
78.00 07800	CAR T-CELL IMMUNOTHERAPY	0	0	78.00
OUTPATIENT SERVICE COST CENTERS				
90.00 09000	CLINIC	0	0	90.00
90.01 09001	WOUND/OSTOMY CLINIC	109,178	0	90.01
90.02 09002	CTR ADVANCED HEART CARE	4,375	0	90.02
90.03 09003	RADIATION ONCOLOGY	156,585	0	90.03
90.04 09004	DIABETIC PLUS CLINIC	9,448	0	90.04
90.05 09005	ANTI COAGULATION CLINIC	4,313	0	90.05
90.06 09006	MAB 3611 REED	0	0	90.06
91.00 09100	EMERGENCY	324,347	0	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	34,343	0	92.00
200.00	Subtotal (see instructions)	1,765,713	0	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00	Net Charges (line 200 - line 201)	1,765,713	0	202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0113	Period: From 01/01/2023 To 12/31/2023	Worksheet D-1 Date/Time Prepared: 5/24/2024 11:54 am
Cost Center Description		Title XVIII	Hospital	PPS
		1.00		
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		21,175	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		21,175	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)		19,164	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		4,710	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		31,564,123	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		31,564,123	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)		31,564,123	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,490.63	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		7,020,867	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)		7,020,867	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0113		Period: From 01/01/2023 To 12/31/2023		Worksheet D-1	
Date/Time Prepared: 5/24/2024 11:54 am		Title XVIII		Hospital		PPS	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0		42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT	10,329,821	4,135	2,498.14	1,168	2,917,828		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)					8,918,137		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)					18,856,832		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)					533,891		50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					597,044		51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					1,130,935		52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					17,725,897		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)					2,011		87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,490.63		88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					2,997,657		89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0113		Period: From 01/01/2023 To 12/31/2023		Worksheet D-1 Date/Time Prepared: 5/24/2024 11:54 am	
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)	PPS
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	1,658,719	31,564,123	0.052551	2,997,657	157,530	90.00
91.00	Nursing Program cost	0	31,564,123	0.000000	2,997,657	0	91.00
92.00	Allied health cost	0	31,564,123	0.000000	2,997,657	0	92.00
93.00	All other Medical Education	0	31,564,123	0.000000	2,997,657	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0113	Period: From 01/01/2023 To 12/31/2023	Worksheet D-1 Date/Time Prepared: 5/24/2024 11:54 am
Cost Center Description		Title XIX	Hospital	PPS
		1.00		
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		21,175	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		21,175	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)		19,164	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		677	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)		921	15.00
16.00	Nursery days (title V or XIX only)		727	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		31,564,160	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		31,564,160	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)		31,564,160	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,490.63	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,009,157	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		1,009,157	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0113		Period: From 01/01/2023 To 12/31/2023		Worksheet D-1	
Title XIX		Hospital		PPS		Date/Time Prepared: 5/24/2024 11:54 am	
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)		
42.00 NURSERY (title V & XIX only)	2,917,246	921	3,167.48	727	2,302,758		42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT	10,329,821	4,135	2,498.14	320	799,405		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)					1,242,040		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)					5,353,360		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)					292,441		50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					77,258		51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					369,699		52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					4,983,661		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)					2,011		87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,490.63		88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					2,997,657		89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0113		Period: From 01/01/2023 To 12/31/2023		Worksheet D-1 Date/Time Prepared: 5/24/2024 11:54 am	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	1,658,719	31,564,160	0.052551	2,997,657	157,530	90.00
91.00	Nursing Program cost	0	31,564,160	0.000000	2,997,657	0	91.00
92.00	Allied health cost	0	31,564,160	0.000000	2,997,657	0	92.00
93.00	All other Medical Education	0	31,564,160	0.000000	2,997,657	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0113	Period: From 01/01/2023 To 12/31/2023	Worksheet D-3 Date/Time Prepared: 5/24/2024 11:54 am	
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		11,577,366	30.00
31.00	03100	INTENSIVE CARE UNIT		5,115,588	31.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.135814	10,414,470	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.509279	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.263322	880,054	54.00
54.01	05401	ULTRASOUND	0.108244	361,061	54.01
56.00	05600	RADIOISOTOPE	0.096514	159,149	56.00
57.00	05700	CT SCAN	0.044924	3,359,981	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.118368	647,963	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.074718	2,492,281	59.00
60.00	06000	LABORATORY	0.168478	3,526,703	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.396693	543,526	62.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.211878	3,905,063	65.00
66.00	06600	PHYSICAL THERAPY	0.553756	416,568	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.370669	286,387	67.00
68.00	06800	SPEECH PATHOLOGY	0.375844	208,644	68.00
69.00	06900	ELECTROCARDIOLOGY	0.199067	1,242,638	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.232001	278,877	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.432877	1,925,299	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.454164	2,337,037	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.257063	6,045,447	73.00
74.00	07400	RENAL DIALYSIS	0.349606	414,197	74.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000	0	78.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.000000	0	90.00
90.01	09001	WOUND/OSTOMY CLINIC	0.352919	58,746	90.01
90.02	09002	CTR ADVANCED HEART CARE	0.345445	0	90.02
90.03	09003	RADIATION ONCOLOGY	0.089909	206,246	90.03
90.04	09004	DIABETIC PLUS CLINIC	2.138515	0	90.04
90.05	09005	ANTICOAGULATION CLINIC	0.483793	0	90.05
90.06	09006	MAB 3611 REED	0.000000	0	90.06
91.00	09100	EMERGENCY	0.094437	6,822,989	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.775962	208,597	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		46,741,923	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)		46,741,923	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0113	Period: From 01/01/2023 To 12/31/2023	Worksheet D-3 Date/Time Prepared: 5/24/2024 11:54 am	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		1,916,911	30.00
31.00	03100	INTENSIVE CARE UNIT		1,521,770	31.00
43.00	04300	NURSERY		617,278	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.136140	1,073,946	146,207 50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0 51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.509279	199,831	101,770 52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.263322	102,180	26,906 54.00
54.01	05401	ULTRASOUND	0.108244	107,005	11,583 54.01
56.00	05600	RADIOISOTOPE	0.096514	7,005	676 56.00
57.00	05700	CT SCAN	0.044924	382,328	17,176 57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.118368	84,485	10,000 58.00
59.00	05900	CARDIAC CATHETERIZATION	0.074718	63,949	4,778 59.00
60.00	06000	LABORATORY	0.168478	544,013	91,654 60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.396693	91,604	36,339 62.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0 64.00
65.00	06500	RESPIRATORY THERAPY	0.211878	709,637	150,356 65.00
66.00	06600	PHYSICAL THERAPY	0.553756	37,099	20,544 66.00
67.00	06700	OCCUPATIONAL THERAPY	0.370669	29,570	10,961 67.00
68.00	06800	SPEECH PATHOLOGY	0.375844	24,457	9,192 68.00
69.00	06900	ELECTROCARDIOLOGY	0.199067	116,268	23,145 69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.232001	38,485	8,929 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.432877	302,623	130,999 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.454164	142,923	64,910 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.257063	1,021,063	262,478 73.00
74.00	07400	RENAL DIALYSIS	0.349606	67,749	23,685 74.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0 77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000	0	0 78.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.000000	0	0 90.00
90.01	09001	WOUND/OSTOMY CLINIC	0.352919	10,324	3,644 90.01
90.02	09002	CTR ADVANCED HEART CARE	0.345445	269	93 90.02
90.03	09003	RADIATION ONCOLOGY	0.089909	899	81 90.03
90.04	09004	DIABETIC PLUS CLINIC	2.138515	0	0 90.04
90.05	09005	ANTICOAGULATION CLINIC	0.483793	0	0 90.05
90.06	09006	MAB 3611 REED	0.000000	0	0 90.06
91.00	09100	EMERGENCY	0.094437	885,882	83,660 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.775962	2,930	2,274 92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		6,046,524	1,242,040 200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	201.00
202.00		Net charges (line 200 minus line 201)		6,046,524	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0113	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part A Date/Time Prepared: 5/24/2024 11:54 am
		Title XVIII	Hospital	PPS
		1.00		
PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS				
1.00	DRG Amounts Other than Outlier Payments		0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)		9,584,447	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		3,110,229	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)		0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)		0	1.04
2.00	Outlier payments for discharges. (see instructions)			2.00
2.01	Outlier reconciliation amount		0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)		0	2.02
2.03	Outlier payments for discharges occurring prior to October 1 (see instructions)		617,159	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)		26,377	2.04
3.00	Managed Care Simulated Payments		17,559,809	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		113.12	4.00
Indirect Medical Education Adjustment				
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996. (see instructions)		0.00	5.00
5.01	FTE cap adjustment for qualifying hospitals under §131 of the CAA 2021 (see instructions)		0.00	5.01
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00	6.00
6.26	Rural track program FTE cap limitation adjustment after the cap-building window closed under §127 of the CAA 2021 (see instructions)		0.00	6.26
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00	7.01
7.02	Adjustment (increase or decrease) to the hospital's rural track program FTE limitation(s) for rural track programs with a rural track for Medicare GME affiliated programs in accordance with 413.75(b) and 87 FR 49075 (August 10, 2022) (see instructions)		0.00	7.02
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).		0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)		0.00	8.02
8.21	The amount of increase if the hospital was awarded FTE cap slots under §126 of the CAA 2021 (see instructions)		0.00	8.21
9.00	Sum of lines 5 and 5.01, plus line 6, plus lines 6.26 through 6.49, minus lines 7 and 7.01, plus or minus line 7.02, plus/minus line 8, plus lines 8.01 through 8.27 (see instructions)		0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.		0.16	11.00
12.00	Current year allowable FTE (see instructions)		0.16	12.00
13.00	Total allowable FTE count for the prior year.		0.16	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		0.25	14.00
15.00	Sum of lines 12 through 14 divided by 3.		0.19	15.00
16.00	Adjustment for residents in initial years of the program (see instructions)		0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure		0.00	17.00
18.00	Adjusted rolling average FTE count		0.19	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.001680	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.001318	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.001318	21.00
22.00	IME payment adjustment (see instructions)		9,153	22.00
22.01	IME payment adjustment - Managed Care (see instructions)		12,661	22.01
Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA				
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).		0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)		0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)		0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)		0	28.01
29.00	Total IME payment (sum of lines 22 and 28)		9,153	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		12,661	29.01
Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		4.29	30.00
31.00	Percentage of Medicaid patient days (see instructions)		25.93	31.00
32.00	Sum of lines 30 and 31		30.22	32.00
33.00	Allowable disproportionate share percentage (see instructions)		14.15	33.00
34.00	Disproportionate share adjustment (see instructions)		449,074	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0113	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part A Date/Time Prepared: 5/24/2024 11:54 am
		Title XVIII	Hospital	PPS
		Prior to 10/1	On/After 10/1	
		1.00	2.00	
Uncompensated Care Payment Adjustment				
35.00	Total uncompensated care amount (see instructions)	6,874,403,459	5,938,006,757	35.00
35.01	Factor 3 (see instructions)	0.000124273	0.000126319	35.01
35.02	Hospital UCP, including supplemental UCP (see instructions)	854,301	750,082	35.02
35.03	Pro rata share of the hospital UCP, including supplemental UCP (see instructions)	638,970	188,545	35.03
36.00	Total UCP adjustment (sum of columns 1 and 2 on line 35.03)	827,515		36.00
Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)				
40.00	Total Medicare discharges (see instructions)	0		40.00
41.00	Total ESRD Medicare discharges (see instructions)	0		41.00
41.01	Total ESRD Medicare covered and paid discharges (see instructions)	0		41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00		42.00
43.00	Total Medicare ESRD inpatient days (see instructions)	0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)	0		46.00
47.00	Subtotal (see instructions)	14,623,954		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)	0		48.00
				Amount
				1.00
49.00	Total payment for inpatient operating costs (see instructions)		14,636,615	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		1,034,695	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)		0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).		6,838	52.00
53.00	Nursing and Allied Health Managed Care payment		0	53.00
54.00	Special add-on payments for new technologies		49,787	54.00
54.01	Islet isolation add-on payment		0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)		0	55.00
55.01	Cellular therapy acquisition cost (see instructions)		0	55.01
56.00	Cost of physicians' services in a teaching hospital (see instructions)		0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).		0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		0	58.00
59.00	Total (sum of amounts on lines 49 through 58)		15,727,935	59.00
60.00	Primary payer payments		0	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		15,727,935	61.00
62.00	Deductibles billed to program beneficiaries		1,535,252	62.00
63.00	Coinurance billed to program beneficiaries		1,600	63.00
64.00	Allowable bad debts (see instructions)		40,477	64.00
65.00	Adjusted reimbursable bad debts (see instructions)		26,310	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		16,479	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		14,217,393	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)		0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)		0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	70.00
70.50	Rural Community Hospital Demonstration Project (\$410A Demonstration) adjustment (see instructions)		0	70.50
70.75	N95 respirator payment adjustment amount (see instructions)		0	70.75
70.87	Demonstration payment adjustment amount before sequestration		0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)		0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		0	70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)		0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)		0	70.91
70.92	Bundled Model 1 discount amount (see instructions)		0	70.92
70.93	HVBP payment adjustment amount (see instructions)		-30,473	70.93
70.94	HRR adjustment amount (see instructions)		-57,032	70.94
70.95	Recovery of accelerated depreciation		0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0113	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part A Date/Time Prepared: 5/24/2024 11:54 am	
		Title XVIII	Hospital	PPS	
		FFY (yyyy)		Amount	
		0		1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0		0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0		0	70.97
70.98	Low Volume Payment-3	0		0	70.98
70.99	HAC adjustment amount (see instructions)			36,392	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)			14,093,496	71.00
71.01	Sequestration adjustment (see instructions)			281,870	71.01
71.02	Demonstration payment adjustment amount after sequestration			0	71.02
71.03	Sequestration adjustment-PARHM pass-throughs			0	71.03
72.00	Interim payments			13,486,600	72.00
72.01	Interim payments-PARHM			0	72.01
73.00	Tentative settlement (for contractor use only)			0	73.00
73.01	Tentative settlement-PARHM (for contractor use only)			0	73.01
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)			325,026	74.00
74.01	Balance due provider/program-PARHM (see instructions)			0	74.01
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			305,012	75.00
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)					
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)			0	90.00
91.00	Capital outlier from Wkst. L, Pt. 1, line 2			0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)			0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)			0	93.00
94.00	The rate used to calculate the time value of money (see instructions)			0.00	94.00
95.00	Time value of money for operating expenses (see instructions)			0	95.00
96.00	Time value of money for capital related expenses (see instructions)			0	96.00
			Prior to 10/1	On/After 10/1	
			1.00	2.00	
HSP Bonus Payment Amount					
100.00	HSP bonus amount (see instructions)			0	100.00
HVBP Adjustment for HSP Bonus Payment					
101.00	HVBP adjustment factor (see instructions)		0.0000000000	0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)			0	102.00
HRR Adjustment for HSP Bonus Payment					
103.00	HRR adjustment factor (see instructions)		0.0000	0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)			0	104.00
Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment					
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.				200.00
Cost Reimbursement					
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. 11, line 49)				201.00
202.00	Medicare discharges (see instructions)				202.00
203.00	Case-mix adjustment factor (see instructions)				203.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)					
204.00	Medicare target amount				204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)				205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)				206.00
Adjustment to Medicare Part A Inpatient Reimbursement					
207.00	Program reimbursement under the §410A Demonstration (see instructions)				207.00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)				208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)				209.00
210.00	Reserved for future use				210.00
211.00	Total adjustment to Medicare IPPS payments (see instructions)				211.00
Comparison of PPS versus Cost Reimbursement					
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)				212.00
213.00	Low-volume adjustment (see instructions)				213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)				218.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0113	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part B Date/Time Prepared: 5/24/2024 11:54 am
		Title XVIII	Hospital	PPS
		1.00		
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		5,913	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		15,293,076	2.00
3.00	OPPS or REH payments		13,355,290	3.00
4.00	Outlier payment (see instructions)		86,886	4.00
4.01	Outlier reconciliation amount (see instructions)		0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs including REH direct graduate medical education costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		5,913	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		26,533	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)		26,533	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		26,533	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		20,620	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)		5,913	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)		13,442,176	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)		498	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		2,525,106	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)		10,922,485	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		5,546	28.00
28.50	REH facility payment amount (see instructions)			28.50
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27, 28, 28.50 and 29)		10,928,031	30.00
31.00	Primary payer payments		2,761	31.00
32.00	Subtotal (line 30 minus line 31)		10,925,270	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)		105,876	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		68,819	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		98,073	36.00
37.00	Subtotal (see instructions)		10,994,089	37.00
38.00	MSP-LCC reconciliation amount from PS&R		-71	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	39.50
39.75	N95 respirator payment adjustment amount (see instructions)		0	39.75
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		10,994,160	40.00
40.01	Sequestration adjustment (see instructions)		219,883	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		10,821,816	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)		-47,539	43.00
43.01	Balance due provider/program-PARHM (see instructions)			43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0113	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part B Date/Time Prepared: 5/24/2024 11:54 am
		Title XVIII	Hospital	PPS
				1.00
94.00	Total (sum of lines 91 and 93)			0 94.00
				1.00
200.00	MEDICARE PART B ANCILLARY COSTS Part B Combined Billed Days			0 200.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-0113

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

Worksheet E-1
Part I
Date/Time Prepared:
5/24/2024 11:54 am

		Title XVIII		Hospital		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		13,486,600		10,821,816	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00	
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01	
3.02			0		0	3.02	
3.03			0		0	3.03	
3.04			0		0	3.04	
3.05			0		0	3.05	
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50	
3.51			0		0	3.51	
3.52			0		0	3.52	
3.53			0		0	3.53	
3.54			0		0	3.54	
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		13,486,600		10,821,816	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		325,026		0	6.01	
6.02	SETTLEMENT TO PROGRAM		0		47,539	6.02	
7.00	Total Medicare program liability (see instructions)		13,811,626		10,774,277	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: 15-0113	Period: From 01/01/2023 To 12/31/2023	Worksheet E-1 Part II Date/Time Prepared: 5/24/2024 11:54 am
		Title XVIII	Hospital	PPS
				1.00
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14			1.00
2.00	Medicare days (see instructions)			2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			3.00
4.00	Total inpatient days (see instructions)			4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20			6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168			7.00
8.00	Calculation of the HIT incentive payment (see instructions)			8.00
9.00	Sequestration adjustment amount (see instructions)			9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			10.00
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			30.00
31.00	Other Adjustment (specify)			31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)			32.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 15-0113		Period: From 01/01/2023 To 12/31/2023		Worksheet E-4	
		Title XVIII		Hospital		Date/Time Prepared: 5/24/2024 11:54 am	
				PPS			
				1.00			
COMPUTATION OF TOTAL DIRECT GME AMOUNT							
1.00	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996.					0.00	1.00
1.01	FTE cap adjustment under §131 of the CAA 2021 (see instructions)					0.00	1.01
2.00	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e)(1) (see instructions)					0.00	2.00
2.26	Rural track program FTE cap limitation adjustment after the cap-building window closed under §127 of the CAA 2021 (see instructions)					0.00	2.26
3.00	Amount of reduction to Direct GME cap under section 422 of MMA					0.00	3.00
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79 (m). (see instructions for cost reporting periods straddling 7/1/2011)					0.00	3.01
3.02	Adjustment (increase or decrease) to the hospital's rural track FTE limitation(s) for rural track programs with a rural track Medicare GME affiliation agreement in accordance with 413.75(b) and 87 FR 49075 (August 10, 2022) (see instructions)					0.00	3.02
4.00	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f))					0.00	4.00
4.01	ACA Section 5503 increase to the Direct GME FTE Cap (see instructions for cost reporting periods straddling 7/1/2011)					0.00	4.01
4.02	ACA Section 5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)					0.00	4.02
4.21	The amount of increase if the hospital was awarded FTE cap slots under §126 of the CAA 2021 (see instructions)					0.00	4.21
5.00	FTE adjusted cap (line 1 plus and 1.01, plus line 2, plus lines 2.26 through 2.49, minus lines 3 and 3.01, plus or minus line 3.02, plus or minus line 4, plus lines 4.01 through 4.27)					0.00	5.00
6.00	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)					0.00	6.00
7.00	Enter the lesser of line 5 or line 6					0.00	7.00
		Primary Care	Other	Total			
		1.00	2.00	3.00			
8.00	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year.	0.00	0.00	0.00		0.00	8.00
9.00	If line 6 is less than 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount on line 6. For cost reporting periods beginning on or after October 1, 2022, or if Worksheet S-2, Part I, line 68, is "Y", see instructions.	0.00	0.00	0.00		0.00	9.00
10.00	Weighted dental and podiatric resident FTE count for the current year		0.16	0.16			10.00
10.01	Unweighted dental and podiatric resident FTE count for the current year		0.16	0.16			10.01
11.00	Total weighted FTE count	0.00	0.16	0.16			11.00
12.00	Total weighted resident FTE count for the prior cost reporting year (see instructions)	0.00	0.16	0.16			12.00
13.00	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	0.00	0.25	0.25			13.00
14.00	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	0.00	0.19	0.19			14.00
15.00	Adjustment for residents in initial years of new programs	0.00	0.00	0.00			15.00
15.01	Unweighted adjustment for residents in initial years of new programs	0.00	0.00	0.00			15.01
16.00	Adjustment for residents displaced by program or hospital closure	0.00	0.00	0.00			16.00
16.01	Unweighted adjustment for residents displaced by program or hospital closure	0.00	0.00	0.00			16.01
17.00	Adjusted rolling average FTE count	0.00	0.19	0.19			17.00
18.00	Per resident amount	0.00	0.00	0.00			18.00
18.01	Per resident amount under §131 of the CAA 2021	109,467.79	109,467.79	109,467.79			18.01
19.00	Approved amount for resident costs	0	20,799	20,799			19.00
				1.00			
20.00	Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 Sec. 413.79(c)(4)			0.00		0.00	20.00
21.00	Direct GME FTE unweighted resident count over cap (see instructions)			0.00		0.00	21.00
22.00	Allowable additional direct GME FTE Resident Count (see instructions)			0.00		0.00	22.00
23.00	Enter the locality adjustment national average per resident amount (see instructions)			0.00		0.00	23.00
24.00	Multiply line 22 time line 23			0		0	24.00
25.00	Total direct GME amount (sum of lines 19 and 24)			20,799		20,799	25.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS	Provider CCN: 15-0113	Period: From 01/01/2023 To 12/31/2023	Worksheet E-4 Date/Time Prepared: 5/24/2024 11:54 am
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		Title XVIII		Hospital	PPS
		Inpatient Part A	Managed Care	Total	
		1.00	2.00	3.00	
COMPUTATION OF PROGRAM PATIENT LOAD					
26.00	Inpatient Days (see instructions) (Title XIX - see S-2 Part IX, line 3.02, column 2)	5,878	8,425		26.00
27.00	Total Inpatient Days (see instructions)	23,559	23,559		27.00
28.00	Ratio of inpatient days to total inpatient days	0.249501	0.357613		28.00
29.00	Program direct GME amount	5,189	7,438	12,627	29.00
29.01	Percent reduction for MA DGME		3.27		29.01
30.00	Reduction for direct GME payments for Medicare Advantage		243	243	30.00
31.00	Net Program direct GME amount			12,384	31.00
				1.00	
DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING PROGRAM AND PARAMEDICAL EDUCATION COSTS)					
32.00	Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94)			0	32.00
33.00	Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94)			1,535,261	33.00
34.00	Ratio of direct medical education costs to total charges (line 32 ÷ line 33)			0.000000	34.00
35.00	Medicare outpatient ESRD charges (see instructions)			0	35.00
36.00	Medicare outpatient ESRD direct medical education costs (line 34 x line 35)			0	36.00
APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII ONLY					
Part A Reasonable Cost					
37.00	Reasonable cost (see instructions)			18,856,832	37.00
38.00	Organ acquisition and HSCT acquisition costs (see instructions)			0	38.00
39.00	Cost of physicians' services in a teaching hospital (see instructions)			0	39.00
40.00	Primary payer payments (see instructions)			0	40.00
41.00	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)			18,856,832	41.00
Part B Reasonable Cost					
42.00	Reasonable cost (see instructions)			15,298,989	42.00
43.00	Primary payer payments (see instructions)			2,761	43.00
44.00	Total Part B reasonable cost (line 42 minus line 43)			15,296,228	44.00
45.00	Total reasonable cost (sum of lines 41 and 44)			34,153,060	45.00
46.00	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)			0.552127	46.00
47.00	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)			0.447873	47.00
ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B					
48.00	Total program GME payment (line 31)			12,384	48.00
49.00	Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions)			6,838	49.00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)			5,546	50.00

OUTLIER RECONCILIATION AT TENTATIVE SETTLEMENT		Provider CCN: 15-0113	Period: From 01/01/2023 To 12/31/2023	Worksheet E-5 Date/Time Prepared: 5/24/2024 11:54 am
Title XVIII			PPS	
				1.00
TO BE COMPLETED BY CONTRACTOR				
1.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)		0	1.00
2.00	Capital outlier from Wkst. L, Pt. I, line 2		0	2.00
3.00	Operating outlier reconciliation adjustment amount (see instructions)		0	3.00
4.00	Capital outlier reconciliation adjustment amount (see instructions)		0	4.00
5.00	The rate used to calculate the time value of money (see instructions)		0.00	5.00
6.00	Time value of money for operating expenses (see instructions)		0	6.00
7.00	Time value of money for capital related expenses (see instructions)		0	7.00

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

Provider CCN: 15-0113

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

Worksheet G

Date/Time Prepared:
5/24/2024 11:54 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	176,093	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	86,158,077	0	0	0	4.00
5.00	Other receivable	-63,549,865	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	1,022,301	0	0	0	6.00
7.00	Inventory	3,695,214	0	0	0	7.00
8.00	Prepaid expenses	83,915	0	0	0	8.00
9.00	Other current assets	311,387	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	27,897,122	0	0	0	11.00
FIXED ASSETS						
12.00	Land	6,268,153	0	0	0	12.00
13.00	Land improvements	2,289,177	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	86,480,043	0	0	0	15.00
16.00	Accumulated depreciation	0	0	0	0	16.00
17.00	Leasehold improvements	2,763,325	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	85,748,195	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	876,727	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	0	0	0	0	23.00
24.00	Accumulated depreciation	-127,822,634	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	56,602,986	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	1,015,216	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	310,597,429	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	311,612,645	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	396,112,753	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	992,746	0	0	0	37.00
38.00	Salaries, wages, and fees payable	0	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	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	8,872,207	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	9,864,953	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	2,714,513	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	2,714,513	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	12,579,466	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	383,533,287				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)	383,533,287	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	396,112,753	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 15-0113

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

Worksheet G-1

Date/Time Prepared:
5/24/2024 11:54 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		359,338,284		0		1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		24,195,003				2.00
3.00	Total (sum of line 1 and line 2)		383,533,287		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		383,533,287		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		383,533,287		0		19.00
		Endowment Fund		Plant Fund			
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0		0			1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0		0			3.00
4.00	Additions (credit adjustments) (specify)		0				4.00
5.00			0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	Deductions (debit adjustments) (specify)		0				12.00
13.00			0				13.00
14.00			0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	0		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 15-0113

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

Worksheet G-2
Parts I & II
Date/Time Prepared:
5/24/2024 11:54 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	56,773,731		56,773,731	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)	56,773,731		56,773,731	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	20,296,487		20,296,487	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)	20,296,487		20,296,487	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	77,070,218		77,070,218	17.00
18.00	Ancillary services	182,294,824	604,585,078	786,879,902	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	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)	259,365,042	604,585,078	863,950,120	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		224,074,259		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)		224,074,259		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 15-0113

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

Worksheet G-3

Date/Time Prepared:
5/24/2024 11:54 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	863,950,120	1.00
2.00	Less contractual allowances and discounts on patients' accounts	633,659,677	2.00
3.00	Net patient revenues (line 1 minus line 2)	230,290,443	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	224,074,259	4.00
5.00	Net income from service to patients (line 3 minus line 4)	6,216,184	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	249,456	6.00
7.00	Income from investments	1,946,969	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	1,101,369	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	2,414,891	22.00
23.00	Governmental appropriations	0	23.00
24.00	MISC: ALL OTHER REVENUE	12,267,729	24.00
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (sum of lines 6-24)	17,980,414	25.00
26.00	Total (line 5 plus line 25)	24,196,598	26.00
27.00	ROUNDING	-5	27.00
27.02	INCOME TAX EXPENSE	1,600	27.02
28.00	Total other expenses (sum of line 27 and subscripts)	1,595	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	24,195,003	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 15-0113	Period: From 01/01/2023 To 12/31/2023	Worksheet L Parts I-III Date/Time Prepared: 5/24/2024 11:54 am
		Title XVIII	Hospital	PPS
				1.00
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		962,690	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		10,489	2.00
2.01	Model 4 BPCI Capital DRG outlier payments		0	2.01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)		64.96	3.00
4.00	Number of interns & residents (see instructions)		0.19	4.00
5.00	Indirect medical education percentage (see instructions)		0.08	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)		770	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		4.29	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		25.93	8.00
9.00	Sum of lines 7 and 8		30.22	9.00
10.00	Allowable disproportionate share percentage (see instructions)		6.31	10.00
11.00	Disproportionate share adjustment (see instructions)		60,746	11.00
12.00	Total prospective capital payments (see instructions)		1,034,695	12.00
				1.00
PART II - PAYMENT UNDER REASONABLE COST				
1.00	Program inpatient routine capital cost (see instructions)		0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)		0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)		0	3.00
4.00	Capital cost payment factor (see instructions)		0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)		0	5.00
				1.00
PART III - COMPUTATION OF EXCEPTION PAYMENTS				
1.00	Program inpatient capital costs (see instructions)		0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)		0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)		0	3.00
4.00	Applicable exception percentage (see instructions)		0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)		0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)		0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)		0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)		0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)		0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)		0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)		0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)		0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)		0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)		0	14.00
15.00	Current year allowable operating and capital payment (see instructions)		0	15.00
16.00	Current year operating and capital costs (see instructions)		0	16.00
17.00	Current year exception offset amount (see instructions)		0	17.00