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: 15-0128	Period: From 01/01/2023 To 12/31/2023	Worksheet S Parts I-III Date/Time Prepared: 5/24/2024 11:48 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 5/24/2024 Time: 11:48 am
2. [ ] Manually prepared cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no.

Contractor use only

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

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

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by COMMUNITY HOSPITAL SOUTH (15-0128) 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 electronica			4

		Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	HOSPITAL	0	411,866	149,000	0	0	1.00
2.00	SUBPROVIDER - IPF	0	0	0		0	2.00
3.00	SUBPROVIDER - IRF	0	0	0		0	3.00
5.00	SWING BED - SNF	0	0	0		0	5.00
6.00	SWING BED - NF	0				0	6.00
200.00	TOTAL	0	411,866	149,000	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: 15-0128	Period: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part I Date/Time Prepared: 5/24/2024 11:48 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 1402 EAST COUNTY LINE ROAD SOUTH	PO Box:			1.00
2.00	City: INDIANAPOLIS	State: IN	Zip Code: 46227	County: MARION	2.00

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)			
							V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	COMMUNITY HOSPITAL SOUTH	150128	26900	1	07/01/1966	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) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or “N” for no.	N	N	Y	22.03
22.04	Did this hospital receive a geographic reclassification from urban to rural as a result of the revised OMB delineations for statistical areas adopted by CMS in FY 2021? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.				22.04
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	3	N		23.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0128 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I | Date/Time Prepared: 5/24/2024 11:48 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.	1,966	405	1	9	8,162	36	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00

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

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

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

		V	XVIII	XIX	
		1.00	2.00	3.00	
	Prospective Payment System (PPS)-Capital				
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	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 are impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter "Y" for yes; otherwise, enter "N" for no in column 2.	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	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).						61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0128 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I | Date/Time Prepared: 5/24/2024 11:48 am

				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
				1.00	2.00	3.00	
	Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.						
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.00	0.000000	64.00
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	65.00
				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
				1.00	2.00	3.00	
	Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010						
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	2.11	0.000000	66.00
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)	FAMILY MEDICINE	1350	0.00	4.35	0.000000	67.00

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

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

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

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

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

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

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		V	XIX	
		1.00	2.00	
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	N	98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.06
	Rural Providers			
105.00	Does this hospital qualify as a CAH?	N		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			106.00
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)			107.00
107.01	If this facility is a REH (line 3, column 4, is "12"), is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no. (see instructions)			107.01
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0128 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I | Date/Time Prepared: 5/24/2024 11:48 am

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	1,971,017	0	0	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
123.00	Did the facility and/or its subproviders (if applicable) purchase professional services, e.g., legal, accounting, tax preparation, bookkeeping, payroll, and/or management/consulting services, from an unrelated organization? In column 1, enter "Y" for yes or "N" for no. If column 1 is "Y", were the majority of the expenses, i.e., greater than 50% of total professional services expenses, for services purchased from unrelated organizations located in a CBSA outside of the main hospital CBSA? In column 2, enter "Y" for yes or "N" for no.	Y	Y	123.00
	Certified Transplant Center Information			
125.00	Does this facility operate a Medicare-certified transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare-certified kidney transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare-certified heart transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare-certified liver transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare-certified lung transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare-certified pancreas transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare-certified intestinal transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare-certified islet transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	Removed and reserved			133.00
134.00	If this is a hospital-based organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	HB0720	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: WISCONSIN PHYSICIANS SERVICES	Contractor's Number: 08101	141.00
142.00	Street: 1500 NORTH RITTER AVENUE	PO Box:		142.00
143.00	City: INDIANAPOLIS	State: IN	Zip Code: 46219-3095	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: 15-0128 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I Date/Time Prepared: 5/24/2024 11:48 am

						1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.					N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.					N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.					N	149.00
		Part A	Part B	Title V	Title XIX		
		1.00	2.00	3.00	4.00		
	Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)						
155.00	Hospital	N	N	N	N		155.00
156.00	Subprovider - IPF	N	N	N	N		156.00
157.00	Subprovider - IRF	N	N	N	N		157.00
158.00	SUBPROVIDER						158.00
159.00	SNF	N	N	N	N		159.00
160.00	HOME HEALTH AGENCY	N	N	N	N		160.00
161.00	CMHC		N	N	N		161.00
						1.00	
	Multicampus						
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.					N	165.00

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

			1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act			
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.		Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)			168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)			168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)		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. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)	N	0	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-0128 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part II | Date/Time Prepared: 5/24/2024 11:48 am

		Y/N	Date	
		1.00	2.00	
	PART II - HOSPITAL AND HOSPITAL HEATHCARE COMPLEX REIMBURSEMENT QUESTIONNAIRE			
	General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.			
	COMPLETED BY ALL HOSPITALS			
	Provider Organization and Operation			
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00

		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y			3.00

		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	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.	Y		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00

		Y/N	
		1.00	
	Bad Debts		
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N	13.00
14.00	If line 12 is yes, were patient deductibles and/or coinsurance amounts waived? If yes, see instructions.	N	14.00
	Bed Complement		
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.	N	15.00

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	N		N		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	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: 15-0128 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part II Date/Time Prepared: 5/24/2024 11:48 am

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

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

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

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	SHIRLEY	BISHOP	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	SBISHOP@ECOMMUNITY.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-0128	Period: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part II Date/Time Prepared: 5/24/2024 11:48 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: 15-0128 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part I | Date/Time Prepared: 5/24/2024 11:48 am

	Component	Worksheet A Line No.	No. of Beds	Bed Days Available	CAH/REH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	157	57,305	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)		157	57,305	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	12	4,380	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)		169	61,685	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)		169				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: 15-0128 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part I | Date/Time Prepared: 5/24/2024 11:48 am

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	9,086	1,638	35,181			1.00
2.00	HMO and other (see instructions)	10,624	7,506				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)	9,086	1,638	35,181			7.00
8.00	INTENSIVE CARE UNIT	758	195	3,196			8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY		1,204	2,099			13.00
14.00	Total (see instructions)	9,844	3,037	40,476	6.46	943.35	14.00
15.00	CAH visits	0	0	0			15.00
15.10	REH hours and visits	0	0	0			15.10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						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)			76			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				6.46	943.35	27.00
28.00	Observation Bed Days		914	6,670			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			593			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	36	621			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: 15-0128 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part I | Date/Time Prepared: 5/24/2024 11:48 am

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	2,246	345	9,945	1.00
2.00	HMO and other (see instructions)			1,977	1,836		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	2,246	345	9,945	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: 15-0128 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part II | Date/Time Prepared: 5/24/2024 11:48 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	84,227,296	-403,145	83,824,151	1,962,174.17	42.72	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		883,780	0	883,780	7,561.00	116.89	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician and Non Physician-Part B		577,635	0	577,635	10,282.00	56.18	5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		990,422	-8,906	981,516	28,686.00	34.22	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		3,003,161	0	3,003,161	25,973.00	115.63	11.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		681,145	0	681,145	5,125.00	132.91	13.00
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00	14.00
14.01	Home office salaries		23,300,112	0	23,300,112	498,588.00	46.73	14.01
14.02	Related organization salaries		0	0	0	0.00	0.00	14.02
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
16.01	Home office Physicians Part A - Teaching		0	0	0	0.00	0.00	16.01
16.02	Home office contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.02
	WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		20,385,072	0	20,385,072			17.00
18.00	Wage-related costs (other) (see instructions)							18.00
19.00	Excluded areas		287,773	0	287,773			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		99,714	0	99,714			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		119,799	0	119,799			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
25.50	Home office wage-related (core)		6,110,891	0	6,110,891			25.50
25.51	Related organization wage-related (core)		0	0	0			25.51
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0			25.52

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0128 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part II | Date/Time Prepared: 5/24/2024 11:48 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	4.00	0	0	0	0.00	0.00	26.00
27.00	Administrative & General	5.00	4,371,415	-39,842	4,331,573	112,053.00	38.66	27.00
28.00	Administrative & General under contract (see inst.)		4,115,402	0	4,115,402	29,811.00	138.05	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	867,528	-20,902	846,626	22,267.00	38.02	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	1,670,442	-9,597	1,660,845	81,162.00	20.46	32.00
33.00	Housekeeping under contract (see instructions)		323,603	0	323,603	6,483.00	49.92	33.00
34.00	Dietary	10.00	1,528,889	-1,045,746	483,143	22,885.00	21.11	34.00
35.00	Dietary under contract (see instructions)		312,913	0	312,913	5,115.00	61.18	35.00
36.00	Cafeteria	11.00	0	1,043,379	1,043,379	49,181.00	21.22	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	377,010	-964	376,046	19,072.00	19.72	38.00
39.00	Central Services and Supply	14.00	0	0	0	0.00	0.00	39.00
40.00	Pharmacy	15.00	0	0	0	0.00	0.00	40.00
41.00	Medical Records & Medical Records Library	16.00	0	0	0	0.00	0.00	41.00
42.00	Social Service	17.00	1,538,069	-2,784	1,535,285	34,629.00	44.34	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0128 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part III Date/Time Prepared: 5/24/2024 11:48 am

		Worksheet A Line Number	Amount Reported	Reclassification 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)		88,401,579	-403,145	87,998,434	1,993,301.17	44.15	1.00
2.00	Excluded area salaries (see instructions)		990,422	-8,906	981,516	28,686.00	34.22	2.00
3.00	Subtotal salaries (line 1 minus line 2)		87,411,157	-394,239	87,016,918	1,964,615.17	44.29	3.00
4.00	Subtotal other wages & related costs (see inst.)		26,984,418	0	26,984,418	529,686.00	50.94	4.00
5.00	Subtotal wage-related costs (see inst.)		26,595,677	0	26,595,677	0.00	30.56	5.00
6.00	Total (sum of lines 3 thru 5)		140,991,252	-394,239	140,597,013	2,494,301.17	56.37	6.00
7.00	Total overhead cost (see instructions)		15,105,271	-76,456	15,028,815	382,658.00	39.27	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 15-0128 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part IV Date/Time Prepared: 5/24/2024 11:48 am

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	3,063,381	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)	25,968	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	619,246	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)	7,823,842	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	1,940,153	9.00
10.00	Dental, Hearing and Vision Plan	66,613	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	32,962	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)	901,734	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	255,815	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	6,158,644	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	0	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	4,000	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	20,892,358	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: 15-0128 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part V | Date/Time Prepared: 5/24/2024 11:48 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	3,003,161	20,892,358	1.00
2.00	Hospital	3,003,161	20,604,585	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	287,773	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 15-0128	Period: From 01/01/2023 To 12/31/2023	Worksheet S-10 Parts I & II Date/Time Prepared: 5/24/2024 11:48 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)	0.190168	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	58,155,912	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	-18,782,281	5.00
6.00	Medicaid charges	249,601,920	6.00
7.00	Medicaid cost (line 1 times line 6)	47,466,298	7.00
8.00	Difference between net revenue and costs for Medicaid program (see instructions)	8,092,667	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	0	9.00
10.00	Stand-alone CHIP charges	0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (see instructions)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (see instructions)	0	16.00
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	8,092,667	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)	7,847,489	3,770,814	11,618,303	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	1,492,341	3,009,434	4,501,775	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)	1,492,341	3,009,434	4,501,775	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)	940,170	25.01
26.00	Bad debt amount (see instructions)	13,406,526	26.00
27.00	Medicare reimbursable bad debts (see instructions)	452,379	27.00
27.01	Medicare allowable bad debts (see instructions)	695,968	27.01
28.00	Non-Medicare bad debt amount (see instructions)	12,710,558	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)	2,660,730	29.00
30.00	Cost of uncompensated care (line 23, col. 3, plus line 29)	7,162,505	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	15,255,172	31.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 15-0128	Period: From 01/01/2023 To 12/31/2023	Worksheet S-10 Parts I & II Date/Time Prepared: 5/24/2024 11:48 am

		1.00	
	PART II - HOSPITAL DATA		
	Uncompensated and Indigent Care Cost-to-Charge Ratio		
1.00	Cost to charge ratio (see instructions)	0.190168	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)	7,847,489	3,770,814	11,618,303	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	1,492,341	3,009,434	4,501,775	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)	1,492,341	3,009,434	4,501,775	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)	940,170	25.01
26.00	Bad debt amount (see instructions)	13,406,526	26.00
27.00	Medicare reimbursable bad debts (see instructions)	452,379	27.00
27.01	Medicare allowable bad debts (see instructions)	695,968	27.01
28.00	Non-Medicare bad debt amount (see instructions)	12,710,558	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)	2,660,730	29.00
30.00	Cost of uncompensated care (line 23, col. 3, plus line 29)	7,162,505	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	7,162,505	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0128 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A | Date/Time Prepared: 5/24/2024 11:48 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		0	0	11,026,646	11,026,646	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	7,467,528	7,467,528	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	16	16	0	16	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	4,371,415	93,591,494	97,962,909	-9,937,518	88,025,391	5.00
7.00	00700	OPERATION OF PLANT	867,528	4,339,487	5,207,015	-117,016	5,089,999	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	709,366	709,366	0	709,366	8.00
9.00	00900	HOUSEKEEPING	1,670,442	1,235,880	2,906,322	-16,274	2,890,048	9.00
10.00	01000	DIETARY	1,528,889	2,163,029	3,691,918	-2,528,369	1,163,549	10.00
11.00	01100	CAFETERIA	0	0	0	2,500,509	2,500,509	11.00
13.00	01300	NURSING ADMINISTRATION	377,010	89,057	466,067	0	466,067	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	1,538,069	455,686	1,993,755	-1,841	1,991,914	17.00
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
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	31,387,435	20,853,704	52,241,139	-7,822,606	44,418,533	30.00
31.00	03100	INTENSIVE CARE UNIT	3,809,563	1,696,126	5,505,689	-432,567	5,073,122	31.00
43.00	04300	NURSERY	0	0	0	988,853	988,853	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,794,345	24,737,444	28,531,789	-17,541,366	10,990,423	50.00
51.00	05100	RECOVERY ROOM	3,569,072	1,706,769	5,275,841	-364,522	4,911,319	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	641,736	25,618	667,354	5,049,383	5,716,737	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,260,916	2,348,295	4,609,211	-1,315,915	3,293,296	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	819,475	2,521,722	3,341,197	-1,657,064	1,684,133	55.00
57.00	05700	CT SCAN	1,068,921	1,701,620	2,770,541	-231,963	2,538,578	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	643,106	522,280	1,165,386	-153,556	1,011,830	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,641,966	9,895,693	11,537,659	-8,148,936	3,388,723	59.00
60.00	06000	LABORATORY	0	9,610,009	9,610,009	-2,173	9,607,836	60.00
64.00	06400	INTRAVENOUS THERAPY	655,326	1,065,949	1,721,275	-95,020	1,626,255	64.00
65.00	06500	RESPIRATORY THERAPY	2,482,612	1,246,647	3,729,259	-432,038	3,297,221	65.00
66.00	06600	PHYSICAL THERAPY	3,652,475	1,654,366	5,306,841	-1,704,500	3,602,341	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,041,160	1,041,160	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	219,208	219,208	68.00
69.00	06900	ELECTROCARDIOLOGY	1,304,859	1,010,150	2,315,009	-257,704	2,057,305	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	541,923	439,375	981,298	-157,678	823,620	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	589,397	1,630,378	2,219,775	15,107,860	17,327,635	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	11,698,761	11,698,761	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,650,142	8,823,878	12,474,020	-120,379	12,353,641	73.00
74.00	07400	RENAL DIALYSIS	533,815	479,428	1,013,243	-93,164	920,079	74.00
76.00	03950	ENDOSCOPY	656,255	1,249,266	1,905,521	-876,662	1,028,859	76.00
76.06	03330	IMAGING CENTER	1,111,193	1,194,358	2,305,551	-558,834	1,746,717	76.06
76.97	07697	CARDIAC REHABILITATION	391,370	150,275	541,645	-27,379	514,266	76.97
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	04950	DIABETIC CARE CENTER	0	0	0	0	0	90.01
90.02	04951	ANTI-COAGULATION CLINIC	623,149	184,528	807,677	-14,243	793,434	90.02
90.03	04952	PALLIATIVE CARE	0	0	0	0	0	90.03
90.04	04953	SPINE CENTER	182,574	150,126	332,700	-73,817	258,883	90.04
91.00	09100	EMERGENCY	6,871,896	4,599,078	11,470,974	-436,821	11,034,153	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)	83,236,874	202,081,097	285,317,971	-20,017	285,297,954	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	107,297	107,297	0	107,297	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	HOME OFFICE	0	0	0	0	0	194.00
194.06	07956	LEASED OFFICE SPACE	0	0	0	0	0	194.06
194.08	07958	MISC NONREIMBURSABLE COST CENTERS	990,422	717,631	1,708,053	20,017	1,728,070	194.08
200.00		TOTAL (SUM OF LINES 118 through 199)	84,227,296	202,906,025	287,133,321	0	287,133,321	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0128 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A | Date/Time Prepared: 5/24/2024 11:48 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	-3,442,502	7,584,144		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	1,839,288	9,306,816		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	3,461,929	3,461,945		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-47,417,681	40,607,710		5.00
7.00	00700	OPERATION OF PLANT	1,543,908	6,633,907		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	709,366		8.00
9.00	00900	HOUSEKEEPING	0	2,890,048		9.00
10.00	01000	DIETARY	-22,879	1,140,670		10.00
11.00	01100	CAFETERIA	-1,497,228	1,003,281		11.00
13.00	01300	NURSING ADMINISTRATION	2,146,913	2,612,980		13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,524,122	1,524,122		16.00
17.00	01700	SOCIAL SERVICE	0	1,991,914		17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	575,572	575,572		21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	1,360,626	1,360,626		22.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-8,603,835	35,814,698		30.00
31.00	03100	INTENSIVE CARE UNIT	0	5,073,122		31.00
43.00	04300	NURSERY	0	988,853		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-2,913,154	8,077,269		50.00
51.00	05100	RECOVERY ROOM	0	4,911,319		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	5,716,737		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-150,535	3,142,761		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	1,684,133		55.00
57.00	05700	CT SCAN	0	2,538,578		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	1,011,830		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	3,388,723		59.00
60.00	06000	LABORATORY	0	9,607,836		60.00
64.00	06400	INTRAVENOUS THERAPY	-968	1,625,287		64.00
65.00	06500	RESPIRATORY THERAPY	0	3,297,221		65.00
66.00	06600	PHYSICAL THERAPY	-963	3,601,378		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,041,160		67.00
68.00	06800	SPEECH PATHOLOGY	0	219,208		68.00
69.00	06900	ELECTROCARDIOLOGY	0	2,057,305		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	131,101	954,721		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	615,346	17,942,981		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	11,698,761		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	113,213	12,466,854		73.00
74.00	07400	RENAL DIALYSIS	0	920,079		74.00
76.00	03950	ENDOSCOPY	0	1,028,859		76.00
76.06	03330	IMAGING CENTER	0	1,746,717		76.06
76.97	07697	CARDIAC REHABILITATION	-12,730	501,536		76.97
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	04950	DIABETIC CARE CENTER	0	0		90.01
90.02	04951	ANTI-COAGULATION CLINIC	-382,737	410,697		90.02
90.03	04952	PALLIATIVE CARE	0	0		90.03
90.04	04953	SPINE CENTER	0	258,883		90.04
91.00	09100	EMERGENCY	206,734	11,240,887		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		OTHER REIMBURSABLE COST CENTERS				
102.00	10200	OPIOID TREATMENT PROGRAM	0	0		102.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-50,926,460	234,371,494		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
191.00	19100	RESEARCH	0	0		191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	107,297		192.00
193.00	19300	NONPAID WORKERS	0	0		193.00
194.00	07950	HOME OFFICE	0	0		194.00
194.06	07956	LEASED OFFICE SPACE	0	0		194.06
194.08	07958	MISC NONREIMBURSABLE COST CENTERS	0	1,728,070		194.08
200.00		TOTAL (SUM OF LINES 118 through 199)	-50,926,460	236,206,861		200.00

RECLASSIFICATIONS | Provider CCN: 15-0128 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-6 | Date/Time Prepared: 5/24/2024 11:48 am

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - Chargeable Medical Supplies					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	16,579,884		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
	TOTALS		0	16,579,884		
	B - Implantable Device Reclass					
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	11,698,761		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
	TOTALS		0	11,698,761		
	C - Drugs Charges to Pat					
1.00	RADIOLOGY-THERAPEUTIC	55.00	0	1		1.00
2.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	6,041		2.00
3.00	DRUGS CHARGED TO PATIENTS	73.00	0	472,113		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
	TOTALS		0	478,155		
	D - Depreciation Expense					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	9,072,352		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
23.00		0.00	0	0		23.00
24.00		0.00	0	0		24.00
25.00		0.00	0	0		25.00

RECLASSIFICATIONS | Provider CCN: 15-0128 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-6 | Date/Time Prepared: 5/24/2024 11:48 am

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
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
	TOTALS		0	9,072,352		
	E - Interest Expense					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	5,779,742		1.00
	TOTALS		0	5,779,742		
	F - Other Capital Rental					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	3,381,128		1.00
2.00	MISC NONREIMBURSABLE COST CENTERS	194.08	0	24,269		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
	TOTALS		0	3,405,397		
	G - STD BENEFIT					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	39,842		1.00
2.00	OPERATION OF PLANT	7.00	0	20,902		2.00
3.00	HOUSEKEEPING	9.00	0	9,597		3.00
4.00	DIETARY	10.00	0	2,367		4.00
5.00	NURSING ADMINISTRATION	13.00	0	964		5.00
6.00	SOCIAL SERVICE	17.00	0	2,784		6.00
7.00	ADULTS & PEDIATRICS	30.00	0	127,218		7.00
8.00	INTENSIVE CARE UNIT	31.00	0	3,725		8.00
9.00	OPERATING ROOM	50.00	0	22,159		9.00
10.00	RECOVERY ROOM	51.00	0	18,887		10.00
11.00	RADIOLOGY-DIAGNOSTIC	54.00	0	12,718		11.00
12.00	RADIOLOGY-THERAPEUTIC	55.00	0	3,491		12.00
13.00	CT SCAN	57.00	0	520		13.00
14.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	5,301		14.00
15.00	RESPIRATORY THERAPY	65.00	0	18,062		15.00
16.00	PHYSICAL THERAPY	66.00	0	30,020		16.00
17.00	ELECTROCARDIOLOGY	69.00	0	6,669		17.00
18.00	ELECTROENCEPHALOGRAPHY	70.00	0	558		18.00
19.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	2,170		19.00
20.00	DRUGS CHARGED TO PATIENTS	73.00	0	10,561		20.00
21.00	IMAGING CENTER	76.06	0	12,498		21.00
22.00	CARDIAC REHABILITATION	76.97	0	2,954		22.00
23.00	ANTI-COAGULATION CLINIC	90.02	0	9,541		23.00
24.00	EMERGENCY	91.00	0	30,731		24.00
25.00	MISC NONREIMBURSABLE COST CENTERS	194.08	0	8,906		25.00
	TOTALS		0	403,145		
	H - Labor and Delivery					
1.00	NURSERY	43.00	590,276	0		1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	3,014,129	0		2.00
3.00	NURSERY	43.00	0	398,577		3.00
4.00	DELIVERY ROOM & LABOR ROOM	52.00	0	2,035,254		4.00
	TOTALS		3,604,405	2,433,831		
	I - Cafeteria					
1.00	CAFETERIA	11.00	1,043,379	0		1.00
2.00	CAFETERIA	11.00	0	1,457,130		2.00
	TOTALS		1,043,379	1,457,130		

RECLASSIFICATIONS | Provider CCN: 15-0128 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-6 | Date/Time Prepared: 5/24/2024 11:48 am

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	J - Therapy				
1.00	OCCUPATIONAL THERAPY	67.00	781,836	0	1.00
2.00	SPEECH PATHOLOGY	68.00	164,609	0	2.00
3.00	OCCUPATIONAL THERAPY	67.00	0	259,324	3.00
4.00	SPEECH PATHOLOGY	68.00	0	54,599	4.00
	TOTALS		946,445	313,923	
	K - Building Depreciation				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	4,985,952	1.00
	TOTALS		0	4,985,952	
	L - Capital Insurance Costs				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	260,952	1.00
	TOTALS		0	260,952	
	M - Radiology Support Staff				
1.00	RADIOLOGY-THERAPEUTIC	55.00	60,558	0	1.00
2.00	CT SCAN	57.00	188,433	0	2.00
3.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	37,022	0	3.00
4.00	RADIOLOGY-THERAPEUTIC	55.00	0	48,445	4.00
5.00	CT SCAN	57.00	0	150,740	5.00
6.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	29,615	6.00
	TOTALS		286,013	228,800	
500.00	Grand Total: Increases		5,880,242	57,098,024	500.00

RECLASSIFICATIONS | Provider CCN: 15-0128 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-6 | Date/Time Prepared: 5/24/2024 11:48 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	ADULTS & PEDIATRICS	30.00	0	1,302,741	0		1.00
2.00	INTENSIVE CARE UNIT	31.00	0	345,339	0		2.00
3.00	OPERATING ROOM	50.00	0	7,366,667	0		3.00
4.00	RECOVERY ROOM	51.00	0	291,865	0		4.00
5.00	RADIOLOGY-DIAGNOSTIC	54.00	0	391,216	0		5.00
6.00	RADIOLOGY-THERAPEUTIC	55.00	0	1,259,608	0		6.00
7.00	CT SCAN	57.00	0	309,119	0		7.00
8.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	13,221	0		8.00
9.00	CARDIAC CATHETERIZATION	59.00	0	3,629,674	0		9.00
10.00	RESPIRATORY THERAPY	65.00	0	394,326	0		10.00
11.00	PHYSICAL THERAPY	66.00	0	843	0		11.00
12.00	ELECTROCARDIOLOGY	69.00	0	12,573	0		12.00
13.00	ELECTROENCEPHALOGRAPHY	70.00	0	11,953	0		13.00
14.00	DRUGS CHARGED TO PATIENTS	73.00	0	133,373	0		14.00
15.00	RENAL DIALYSIS	74.00	0	74,535	0		15.00
16.00	ENDOSCOPY	76.00	0	672,360	0		16.00
17.00	IMAGING CENTER	76.06	0	47,034	0		17.00
18.00	CARDIAC REHABILITATION	76.97	0	2,055	0		18.00
19.00	EMERGENCY	91.00	0	317,446	0		19.00
20.00	INTRAVENOUS THERAPY	64.00	0	3,936	0		20.00
	TOTALS		0	16,579,884			
	B - Implantable Device Reclass						
1.00	OPERATING ROOM	50.00	0	7,614,334	0		1.00
2.00	RADIOLOGY-THERAPEUTIC	55.00	0	313,098	0		2.00
3.00	CARDIAC CATHETERIZATION	59.00	0	3,771,329	0		3.00
	TOTALS		0	11,698,761			
	C - Drugs Charges to Pat						
1.00	ADULTS & PEDIATRICS	30.00	0	5,285	0		1.00
2.00	INTENSIVE CARE UNIT	31.00	0	1,660	0		2.00
3.00	OPERATING ROOM	50.00	0	6,163	0		3.00
4.00	RECOVERY ROOM	51.00	0	491	0		4.00
5.00	RADIOLOGY-DIAGNOSTIC	54.00	0	154,436	0		5.00
6.00	CT SCAN	57.00	0	233,755	0		6.00
7.00	CARDIAC CATHETERIZATION	59.00	0	18,377	0		7.00
8.00	INTRAVENOUS THERAPY	64.00	0	141	0		8.00
9.00	PHYSICAL THERAPY	66.00	0	401	0		9.00
10.00	ELECTROCARDIOLOGY	69.00	0	26,054	0		10.00
11.00	ELECTROENCEPHALOGRAPHY	70.00	0	266	0		11.00
12.00	ENDOSCOPY	76.00	0	681	0		12.00
13.00	IMAGING CENTER	76.06	0	29,546	0		13.00
14.00	CARDIAC REHABILITATION	76.97	0	2	0		14.00
15.00	ANTI-COAGULATION CLINIC	90.02	0	321	0		15.00
16.00	EMERGENCY	91.00	0	576	0		16.00
	TOTALS		0	478,155			
	D - Depreciation Expense						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	3,828,602	9		1.00
2.00	OPERATION OF PLANT	7.00	0	110,636	0		2.00
3.00	HOUSEKEEPING	9.00	0	4,226	0		3.00
4.00	DIETARY	10.00	0	27,780	0		4.00
5.00	SOCIAL SERVICE	17.00	0	1,805	0		5.00
6.00	ADULTS & PEDIATRICS	30.00	0	413,683	0		6.00
7.00	INTENSIVE CARE UNIT	31.00	0	85,568	0		7.00
8.00	OPERATING ROOM	50.00	0	1,923,930	0		8.00
9.00	RECOVERY ROOM	51.00	0	71,214	0		9.00
10.00	RADIOLOGY-DIAGNOSTIC	54.00	0	255,450	0		10.00
11.00	RADIOLOGY-THERAPEUTIC	55.00	0	193,281	0		11.00
12.00	CT SCAN	57.00	0	20,602	0		12.00
13.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	206,972	0		13.00
14.00	CARDIAC CATHETERIZATION	59.00	0	728,392	0		14.00
15.00	LABORATORY	60.00	0	2,173	0		15.00
16.00	RESPIRATORY THERAPY	65.00	0	19,711	0		16.00
17.00	PHYSICAL THERAPY	66.00	0	97,094	0		17.00
18.00	ELECTROCARDIOLOGY	69.00	0	218,997	0		18.00
19.00	ELECTROENCEPHALOGRAPHY	70.00	0	34,329	0		19.00
20.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	50,320	0		20.00
21.00	DRUGS CHARGED TO PATIENTS	73.00	0	77,376	0		21.00
22.00	RENAL DIALYSIS	74.00	0	18,629	0		22.00
23.00	ENDOSCOPY	76.00	0	203,181	0		23.00
24.00	IMAGING CENTER	76.06	0	212,681	0		24.00
25.00	CARDIAC REHABILITATION	76.97	0	25,322	0		25.00

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		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
26.00	ANTI-COAGULATION CLINIC	90.02	0	13,922	0		26.00
27.00	SPINE CENTER	90.04	0	12,482	0		27.00
28.00	EMERGENCY	91.00	0	118,799	0		28.00
29.00	MISC NONREIMBURSABLE COST CENTERS	194.08	0	4,252	0		29.00
30.00	INTRAVENOUS THERAPY	64.00	0	90,943	0		30.00
	TOTALS		0	9,072,352			
	E - Interest Expense						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	5,779,742	11		1.00
	TOTALS		0	5,779,742			
	F - Other Capital Rental						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	68,222	10		1.00
2.00	OPERATION OF PLANT	7.00	0	6,380	0		2.00
3.00	HOUSEKEEPING	9.00	0	12,048	0		3.00
4.00	DIETARY	10.00	0	80	0		4.00
5.00	SOCIAL SERVICE	17.00	0	36	0		5.00
6.00	ADULTS & PEDIATRICS	30.00	0	62,661	0		6.00
7.00	OPERATING ROOM	50.00	0	630,272	0		7.00
8.00	RECOVERY ROOM	51.00	0	952	0		8.00
9.00	RADIOLOGY-THERAPEUTIC	55.00	0	81	0		9.00
10.00	CT SCAN	57.00	0	7,660	0		10.00
11.00	CARDIAC CATHETERIZATION	59.00	0	1,164	0		11.00
12.00	RESPIRATORY THERAPY	65.00	0	18,001	0		12.00
13.00	PHYSICAL THERAPY	66.00	0	345,794	0		13.00
14.00	ELECTROCARDIOLOGY	69.00	0	80	0		14.00
15.00	ELECTROENCEPHALOGRAPHY	70.00	0	111,130	0		15.00
16.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	1,427,745	0		16.00
17.00	DRUGS CHARGED TO PATIENTS	73.00	0	381,743	0		17.00
18.00	ENDOSCOPY	76.00	0	440	0		18.00
19.00	IMAGING CENTER	76.06	0	269,573	0		19.00
20.00	SPINE CENTER	90.04	0	61,335	0		20.00
	TOTALS		0	3,405,397			
	G - STD BENEFIT						
1.00	ADMINISTRATIVE & GENERAL	5.00	39,842	0	0		1.00
2.00	OPERATION OF PLANT	7.00	20,902	0	0		2.00
3.00	HOUSEKEEPING	9.00	9,597	0	0		3.00
4.00	DIETARY	10.00	2,367	0	0		4.00
5.00	NURSING ADMINISTRATION	13.00	964	0	0		5.00
6.00	SOCIAL SERVICE	17.00	2,784	0	0		6.00
7.00	ADULTS & PEDIATRICS	30.00	127,218	0	0		7.00
8.00	INTENSIVE CARE UNIT	31.00	3,725	0	0		8.00
9.00	OPERATING ROOM	50.00	22,159	0	0		9.00
10.00	RECOVERY ROOM	51.00	18,887	0	0		10.00
11.00	RADIOLOGY-DIAGNOSTIC	54.00	12,718	0	0		11.00
12.00	RADIOLOGY-THERAPEUTIC	55.00	3,491	0	0		12.00
13.00	CT SCAN	57.00	520	0	0		13.00
14.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	5,301	0	0		14.00
15.00	RESPIRATORY THERAPY	65.00	18,062	0	0		15.00
16.00	PHYSICAL THERAPY	66.00	30,020	0	0		16.00
17.00	ELECTROCARDIOLOGY	69.00	6,669	0	0		17.00
18.00	ELECTROENCEPHALOGRAPHY	70.00	558	0	0		18.00
19.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	2,170	0	0		19.00
20.00	DRUGS CHARGED TO PATIENTS	73.00	10,561	0	0		20.00
21.00	IMAGING CENTER	76.06	12,498	0	0		21.00
22.00	CARDIAC REHABILITATION	76.97	2,954	0	0		22.00
23.00	ANTI-COAGULATION CLINIC	90.02	9,541	0	0		23.00
24.00	EMERGENCY	91.00	30,731	0	0		24.00
25.00	MISC NONREIMBURSABLE COST CENTERS	194.08	8,906	0	0		25.00
	TOTALS		403,145	0			
	H - Labor and Delivery						
1.00	ADULTS & PEDIATRICS	30.00	3,604,405	0	0		1.00
2.00		0.00	0	0	0		2.00
3.00	ADULTS & PEDIATRICS	30.00	0	2,433,831	0		3.00
4.00		0.00	0	0	0		4.00
	TOTALS		3,604,405	2,433,831			
	I - Cafeteria						
1.00	DIETARY	10.00	1,043,379	0	0		1.00
2.00	DIETARY	10.00	0	1,457,130	0		2.00
	TOTALS		1,043,379	1,457,130			

RECLASSIFICATIONS | Provider CCN: 15-0128 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-6 | Date/Time Prepared: 5/24/2024 11:48 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	J - Therapy						
1.00	PHYSICAL THERAPY	66.00	946,445	0	0		1.00
2.00		0.00	0	0	0		2.00
3.00	PHYSICAL THERAPY	66.00	0	313,923	0		3.00
4.00		0.00	0	0	0		4.00
	TOTALS		946,445	313,923			
	K - Building Depreciation						
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	4,985,952	9		1.00
	TOTALS		0	4,985,952			
	L - Capital Insurance Costs						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	260,952	12		1.00
	TOTALS		0	260,952			
	M - Radiology Support Staff						
1.00	RADIOLOGY-DIAGNOSTIC	54.00	286,013	0	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00	RADIOLOGY-DIAGNOSTIC	54.00	0	228,800	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
	TOTALS		286,013	228,800			
500.00	Grand Total: Decreases		6,283,387	56,694,879			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0128 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-7 Part I | Date/Time Prepared: 5/24/2024 11:48 am

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	5,442,087	853	0	853	0	1.00
2.00	Land Improvements	3,022,362	0	0	0	0	2.00
3.00	Buildings and Fixtures	194,621,714	5,496,366	0	5,496,366	0	3.00
4.00	Building Improvements	1,769,784	0	0	0	315,145	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	91,003,607	2,888,003	0	2,888,003	2,378,604	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	295,859,554	8,385,222	0	8,385,222	2,693,749	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	295,859,554	8,385,222	0	8,385,222	2,693,749	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	5,442,940	0	1.00
2.00	Land Improvements	3,022,362	0	2.00
3.00	Buildings and Fixtures	200,118,080	0	3.00
4.00	Building Improvements	1,454,639	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	91,513,006	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	301,551,027	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	301,551,027	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0128 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-7 Part II | Date/Time Prepared: 5/24/2024 11:48 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: 15-0128 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-7 Part III Date/Time Prepared: 5/24/2024 11:48 am

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	210,038,022	0	210,038,022	0.696526	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	91,513,006	0	91,513,006	0.303474	0	2.00
3.00	Total (sum of lines 1-2)	301,551,028	0	301,551,028	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	4,985,952	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	5,925,688	3,381,128	2.00
3.00	Total (sum of lines 1-2)	0	0	0	10,911,640	3,381,128	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	2,337,240	260,952	0	0	7,584,144	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	9,306,816	2.00
3.00	Total (sum of lines 1-2)	2,337,240	260,952	0	0	16,890,960	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0128 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-8 | Date/Time Prepared: 5/24/2024 11:48 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)	B	0	ADMINISTRATIVE & GENERAL	5.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)	B	-23,286	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	-803,075			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	3,612,119			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-1,377,210	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		0		0.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	NA	A	0	OPERATING ROOM	50.00	0	33.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0128 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-8 | Date/Time Prepared: 5/24/2024 11:48 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.01	Misc Revenue	B	-49,082	ADMINISTRATIVE & GENERAL	5.00	0	33.01
33.02	Misc Revenue	B	-3,000	OPERATION OF PLANT	7.00	0	33.02
33.03	Misc Revenue	B	-22,879	DIETARY	10.00	0	33.03
33.04	Misc Revenue	B	-320,787	RADIOLOGY-DIAGNOSTIC	54.00	0	33.04
33.05	Misc Revenue	B	-8,224	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	33.05
33.06	Misc Revenue	B	-46,800	DRUGS CHARGED TO PATIENTS	73.00	0	33.06
33.07	Space Rental Income	B	-747,893	OPERATION OF PLANT	7.00	0	33.07
33.08	Loss on Assets	A	-30,000	OPERATING ROOM	50.00	0	33.08
33.09	Loss on Assets	A	-38,415	RADIOLOGY-DIAGNOSTIC	54.00	0	33.09
33.10	Loss on Assets	A	-963	PHYSICAL THERAPY	66.00	0	33.10
34.00	HAF Tax Offset	A	-19,205,142	ADMINISTRATIVE & GENERAL	5.00	0	34.00
34.01	PNC Non-Allow Interest Expense	A	-15,370	CAP REL COSTS-BLDG & FIXT	1.00	11	34.01
34.02	2012A Non-Allowable Interest Expense	A	-8,795	CAP REL COSTS-BLDG & FIXT	1.00	11	34.02
34.03	2012B Non- Allow Interest Expense	A	-148,955	CAP REL COSTS-BLDG & FIXT	1.00	11	34.03
34.04	2018A Non-Allowable Interest Expense	A	-1,746,205	CAP REL COSTS-BLDG & FIXT	1.00	11	34.04
34.05	2020A Non-Allow Interest Expense	A	-1,229,823	CAP REL COSTS-BLDG & FIXT	1.00	11	34.05
34.06	2022A Non- Allow Interest Expense	A	-293,354	CAP REL COSTS-BLDG & FIXT	1.00	11	34.06
34.07	Non- Allow Debt Issuance Expense	A	-36,383	ADMINISTRATIVE & GENERAL	5.00	0	34.07
35.00	Bad Debt	A	-16,364,219	ADMINISTRATIVE & GENERAL	5.00	0	35.00
35.01	Bad Debt	A	-968	INTRAVENOUS THERAPY	64.00	0	35.01
36.00	Meals on Wheels Cost	A	-120,018	CAFETERIA	11.00	0	36.00
36.01	Hospitalist Loss	A	-8,616,243	ADULTS & PEDIATRICS	30.00	0	36.01
36.02	Hospitalist Loss	A	-2,883,154	OPERATING ROOM	50.00	0	36.02
36.03	APP	A	-12,730	CARDIAC REHABILITATION	76.97	0	36.03
36.04	APP	A	-382,737	ANTI-COAGULATION CLINIC	90.02	0	36.04
36.05	APP	A	-2,869	EMERGENCY	91.00	0	36.05
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-50,926,460				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: 15-0128 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-8-1 | Date/Time Prepared: 5/24/2024 11:48 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	575,572	0	1.00
2.00	22.00	I&R SERVICES-OTHER PRGM. COS	RESIDENTS	1,360,626	0	2.00
3.00	2.00	CAP REL COSTS-MVBLE EQUIP	HOME OFFICE	1,839,288	0	3.00
3.01	4.00	EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE	3,461,929	0	3.01
3.02	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE	34,082,742	45,050,019	3.02
3.03	7.00	OPERATION OF PLANT	HOME OFFICE	2,294,801	0	3.03
3.04	13.00	NURSING ADMINISTRATION	HOME OFFICE	2,146,913	0	3.04
3.05	16.00	MEDICAL RECORDS & LIBRARY	HOME OFFICE	1,524,122	0	3.05
3.06	30.00	ADULTS & PEDIATRICS	HOME OFFICE	12,408	0	3.06
3.07	54.00	RADIOLOGY-DIAGNOSTIC	HOME OFFICE	208,667	0	3.07
3.08	70.00	ELECTROENCEPHALOGRAPHY	HOME OFFICE	131,101	0	3.08
3.09	71.00	MEDICAL SUPPLIES CHARGED TO	HOME OFFICE	623,570	0	3.09
3.10	73.00	DRUGS CHARGED TO PATIENTS	HOME OFFICE	160,013	0	3.10
4.00	5.00	ADMINISTRATIVE & GENERAL	CPN MEDICAL DIRECTOR	30,783	0	4.00
4.01	91.00	EMERGENCY	CPN CALL	209,603	0	4.01
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			48,662,138	45,050,019	5.00

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

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

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

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

6.00	C	CHNW	100.00		0.00	6.00
7.00			0.00		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:	OTHER				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: 15-0128 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-8-1 | Date/Time Prepared: 5/24/2024 11:48 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	575,572	0		1.00
2.00	1,360,626	0		2.00
3.00	1,839,288	9		3.00
3.01	3,461,929	0		3.01
3.02	-10,967,277	0		3.02
3.03	2,294,801	0		3.03
3.04	2,146,913	0		3.04
3.05	1,524,122	0		3.05
3.06	12,408	0		3.06
3.07	208,667	0		3.07
3.08	131,101	0		3.08
3.09	623,570	0		3.09
3.10	160,013	0		3.10
4.00	30,783	0		4.00
4.01	209,603	0		4.01
5.00	3,612,119			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: 15-0128 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-8-2 | Date/Time Prepared: 5/24/2024 11:48 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	803,075	803,075	0	0	0	1.00
2.00	0.00		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			803,075	803,075	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	0.00		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	803,075		1.00
2.00	0.00		0	0	0	0		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	803,075		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0128 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I Date/Time Prepared: 5/24/2024 11:48 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	7,584,144	7,584,144				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	9,306,816		9,306,816			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	3,461,945	0	0	3,461,945		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	40,607,710	382,175	2,442,842	178,894	43,611,621	5.00
7.00	00700	OPERATION OF PLANT	6,633,907	993,324	37,875	34,966	7,700,072	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	709,366	20,681	0	0	730,047	8.00
9.00	00900	HOUSEKEEPING	2,890,048	43,867	15,963	68,593	3,018,471	9.00
10.00	01000	DIETARY	1,140,670	78,362	6,126	19,954	1,245,112	10.00
11.00	01100	CAFETERIA	1,003,281	168,379	18,650	43,092	1,233,402	11.00
13.00	01300	NURSING ADMINISTRATION	2,612,980	0	0	15,531	2,628,511	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,524,122	8,639	0	0	1,532,761	16.00
17.00	01700	SOCIAL SERVICE	1,991,914	20,375	1,806	63,407	2,077,502	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	575,572	0	0	0	575,572	21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	1,360,626	0	0	0	1,360,626	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	35,814,698	1,743,271	210,736	1,142,194	38,910,899	30.00
31.00	03100	INTENSIVE CARE UNIT	5,073,122	552,144	83,933	157,181	5,866,380	31.00
43.00	04300	NURSERY	988,853	57,926	17,612	24,378	1,088,769	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	8,077,269	777,430	1,561,357	155,791	10,571,847	50.00
51.00	05100	RECOVERY ROOM	4,911,319	160,861	70,255	146,623	5,289,058	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	5,716,737	295,805	89,935	150,987	6,253,464	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,142,761	259,986	255,250	81,038	3,739,035	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	1,684,133	0	187,956	36,201	1,908,290	55.00
57.00	05700	CT SCAN	2,538,578	34,923	10,175	51,907	2,635,583	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,011,830	31,867	169,669	27,870	1,241,236	58.00
59.00	05900	CARDIAC CATHETERIZATION	3,388,723	209,863	465,519	67,813	4,131,918	59.00
60.00	06000	LABORATORY	9,607,836	99,206	0	0	9,707,042	60.00
64.00	06400	INTRAVENOUS THERAPY	1,625,287	70,803	68,321	27,065	1,791,476	64.00
65.00	06500	RESPIRATORY THERAPY	3,297,221	48,268	35,048	101,786	3,482,323	65.00
66.00	06600	PHYSICAL THERAPY	3,601,378	15,893	505,932	110,519	4,233,722	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,041,160	4,584	20,387	32,290	1,098,421	67.00
68.00	06800	SPEECH PATHOLOGY	219,208	958	4,292	6,798	231,256	68.00
69.00	06900	ELECTROCARDIOLOGY	2,057,305	113,672	188,621	53,615	2,413,213	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	954,721	47,331	142,680	22,358	1,167,090	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	17,942,981	220,254	1,449,807	24,252	19,637,294	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	11,698,761	0	0	0	11,698,761	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	12,466,854	119,805	411,604	150,315	13,148,578	73.00
74.00	07400	RENAL DIALYSIS	920,079	21,944	13,124	22,047	977,194	74.00
76.00	03950	ENDOSCOPY	1,028,859	0	158,168	27,103	1,214,130	76.00
76.06	03330	IMAGING CENTER	1,746,717	0	471,584	45,376	2,263,677	76.06
76.97	07697	CARDIAC REHABILITATION	501,536	0	19,749	16,042	537,327	76.97
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	04950	DIABETIC CARE CENTER	0	0	0	0	0	90.01
90.02	04951	ANTI-COAGULATION CLINIC	410,697	0	706	25,342	436,745	90.02
90.03	04952	PALLIATIVE CARE	0	0	0	0	0	90.03
90.04	04953	SPINE CENTER	258,883	0	72,324	7,540	338,747	90.04
91.00	09100	EMERGENCY	11,240,887	565,958	98,810	282,540	12,188,195	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	234,371,494	7,168,554	9,306,816	3,421,408	233,915,367	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	23,941	0	0	23,941	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	107,297	0	0	0	107,297	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	HOME OFFICE	0	0	0	0	0	194.00
194.06	07956	LEASED OFFICE SPACE	0	380,545	0	0	380,545	194.06
194.08	07958	MISC NONREIMBURSABLE COST CENTERS	1,728,070	11,104	0	40,537	1,779,711	194.08
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)	236,206,861	7,584,144	9,306,816	3,461,945	236,206,861	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0128 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I | Date/Time Prepared: 5/24/2024 11:48 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	43,611,621					5.00
7.00	00700	OPERATION OF PLANT	1,743,620	9,443,692				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	165,313	31,456	926,816			8.00
9.00	00900	HOUSEKEEPING	683,509	66,725	0	3,768,705		9.00
10.00	01000	DIETARY	281,946	119,194	0	48,066	1,694,318	10.00
11.00	01100	CAFETERIA	279,294	256,114	0	103,282	0	11.00
13.00	01300	NURSING ADMINISTRATION	595,205	0	0	0	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	347,081	13,140	0	5,299	0	16.00
17.00	01700	SOCIAL SERVICE	470,434	30,992	0	12,498	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	130,334	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	308,103	0	0	0	0	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,811,031	2,651,608	373,033	1,069,298	1,547,509	30.00
31.00	03100	INTENSIVE CARE UNIT	1,328,395	839,841	44,558	338,677	146,809	31.00
43.00	04300	NURSERY	246,543	88,109	7,425	35,531	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,393,910	1,182,515	103,550	476,865	0	50.00
51.00	05100	RECOVERY ROOM	1,197,665	244,679	46,131	98,670	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,416,047	449,936	37,909	181,443	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	846,675	395,453	16,601	159,472	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	432,117	0	0	0	0	55.00
57.00	05700	CT SCAN	596,807	53,120	63,844	21,421	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	281,068	48,471	0	19,547	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	935,640	319,213	11,187	128,727	0	59.00
60.00	06000	LABORATORY	2,198,082	150,898	0	60,852	0	60.00
64.00	06400	INTRAVENOUS THERAPY	405,665	107,696	0	43,430	0	64.00
65.00	06500	RESPIRATORY THERAPY	788,544	73,419	0	29,607	0	65.00
66.00	06600	PHYSICAL THERAPY	958,692	24,173	0	9,748	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	248,729	6,973	0	2,812	0	67.00
68.00	06800	SPEECH PATHOLOGY	52,366	1,457	0	587	0	68.00
69.00	06900	ELECTROCARDIOLOGY	546,453	172,902	0	69,725	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	264,278	71,993	0	29,032	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,446,708	335,019	0	135,101	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,649,091	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,977,390	182,230	0	73,487	0	73.00
74.00	07400	RENAL DIALYSIS	221,278	33,378	0	13,460	0	74.00
76.00	03950	ENDOSCOPY	274,930	0	0	0	0	76.00
76.06	03330	IMAGING CENTER	512,592	0	0	0	0	76.06
76.97	07697	CARDIAC REHABILITATION	121,673	0	0	0	0	76.97
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	04950	DIABETIC CARE CENTER	0	0	0	0	0	90.01
90.02	04951	ANTI-COAGULATION CLINIC	98,897	0	0	0	0	90.02
90.03	04952	PALLIATIVE CARE	0	0	0	0	0	90.03
90.04	04953	SPINE CENTER	76,707	0	0	0	0	90.04
91.00	09100	EMERGENCY	2,759,919	860,853	222,578	347,151	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)	43,092,731	8,811,557	926,816	3,513,788	1,694,318	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	5,421	36,415	0	14,685	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	24,297	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	HOME OFFICE	0	0	0	0	0	194.00
194.06	07956	LEASED OFFICE SPACE	86,171	578,830	0	233,421	0	194.06
194.08	07958	MISC NONREIMBURSABLE COST CENTERS	403,001	16,890	0	6,811	0	194.08
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)	43,611,621	9,443,692	926,816	3,768,705	1,694,318	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0128 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I Date/Time Prepared: 5/24/2024 11:48 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES	
			11.00	13.00	16.00	17.00	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
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	1,872,092					11.00
13.00	01300	NURSING ADMINISTRATION	22,346	3,246,062				13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	1,898,281			16.00
17.00	01700	SOCIAL SERVICE	42,209	0	0	2,633,635		17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	705,906	21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	0	0	0	0		22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	707,622	2,301,043	219,280	2,289,107	391,199	30.00
31.00	03100	INTENSIVE CARE UNIT	79,452	259,167	26,758	207,953	44,802	31.00
43.00	04300	NURSERY	14,897	49,927	5,794	136,575	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	116,695	0	245,085	0	167,188	50.00
51.00	05100	RECOVERY ROOM	89,384	0	60,905	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	79,452	0	29,586	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54,623	0	69,119	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	22,346	0	43,046	0	0	55.00
57.00	05700	CT SCAN	34,760	0	156,592	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	17,380	0	30,150	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	39,726	0	199,876	0	18,576	59.00
60.00	06000	LABORATORY	0	0	97,669	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	22,346	0	5,073	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	59,589	0	34,995	0	0	65.00
66.00	06600	PHYSICAL THERAPY	32,277	0	19,694	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	22,346	0	5,935	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	4,966	0	1,249	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	47,175	0	46,991	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	14,897	0	10,394	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	27,312	0	67,528	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	55,770	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	84,418	0	96,056	0	0	73.00
74.00	07400	RENAL DIALYSIS	9,932	0	3,427	0	0	74.00
76.00	03950	ENDOSCOPY	14,897	0	16,287	0	0	76.00
76.06	03330	IMAGING CENTER	0	0	34,164	0	0	76.06
76.97	07697	CARDIAC REHABILITATION	14,897	0	4,076	0	0	76.97
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	04950	DIABETIC CARE CENTER	0	0	0	0	0	90.01
90.02	04951	ANTI-COAGULATION CLINIC	0	0	3,673	0	0	90.02
90.03	04952	PALLIATIVE CARE	0	0	0	0	0	90.03
90.04	04953	SPINE CENTER	0	0	607	0	4,371	90.04
91.00	09100	EMERGENCY	196,148	635,925	308,502	0	79,770	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)	1,872,092	3,246,062	1,898,281	2,633,635	705,906	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	HOME OFFICE	0	0	0	0	0	194.00
194.06	07956	LEASED OFFICE SPACE	0	0	0	0	0	194.06
194.08	07958	MISC NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.08
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,872,092	3,246,062	1,898,281	2,633,635	705,906	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0128 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I | Date/Time Prepared: 5/24/2024 11:48 am

		Cost Center Description	INTERNS & RESIDENTS SERVICES-OTHER PRGM. COSTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			22.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE						17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD						21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	1,668,729					22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	924,775	60,196,404	-1,315,974	58,880,430		30.00
31.00	03100	INTENSIVE CARE UNIT	105,910	9,288,702	-150,712	9,137,990		31.00
43.00	04300	NURSERY	0	1,673,570	0	1,673,570		43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	395,225	15,652,880	-562,413	15,090,467		50.00
51.00	05100	RECOVERY ROOM	0	7,026,492	0	7,026,492		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	8,447,837	0	8,447,837		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	5,280,978	0	5,280,978		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	2,405,799	0	2,405,799		55.00
57.00	05700	CT SCAN	0	3,562,127	0	3,562,127		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	1,637,852	0	1,637,852		58.00
59.00	05900	CARDIAC CATHETERIZATION	43,914	5,828,777	-62,490	5,766,287		59.00
60.00	06000	LABORATORY	0	12,214,543	0	12,214,543		60.00
64.00	06400	INTRAVENOUS THERAPY	0	2,375,686	0	2,375,686		64.00
65.00	06500	RESPIRATORY THERAPY	0	4,468,477	0	4,468,477		65.00
66.00	06600	PHYSICAL THERAPY	0	5,278,306	0	5,278,306		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,385,216	0	1,385,216		67.00
68.00	06800	SPEECH PATHOLOGY	0	291,881	0	291,881		68.00
69.00	06900	ELECTROCARDIOLOGY	0	3,296,459	0	3,296,459		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	1,557,684	0	1,557,684		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	24,648,962	0	24,648,962		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	14,403,622	0	14,403,622		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	16,562,159	0	16,562,159		73.00
74.00	07400	RENAL DIALYSIS	0	1,258,669	0	1,258,669		74.00
76.00	03950	ENDOSCOPY	0	1,520,244	0	1,520,244		76.00
76.06	03330	IMAGING CENTER	0	2,810,433	0	2,810,433		76.06
76.97	07697	CARDIAC REHABILITATION	0	677,973	0	677,973		76.97
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	04950	DIABETIC CARE CENTER	0	0	0	0		90.01
90.02	04951	ANTI-COAGULATION CLINIC	0	539,315	0	539,315		90.02
90.03	04952	PALLIATIVE CARE	0	0	0	0		90.03
90.04	04953	SPINE CENTER	10,333	430,765	-14,704	416,061		90.04
91.00	09100	EMERGENCY	188,572	17,787,613	-268,342	17,519,271		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0		102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,668,729	232,509,425	-2,374,635	230,134,790		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	80,462	0	80,462		190.00
191.00	19100	RESEARCH	0	0	0	0		191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	131,594	0	131,594		192.00
193.00	19300	NONPAID WORKERS	0	0	0	0		193.00
194.00	07950	HOME OFFICE	0	0	0	0		194.00
194.06	07956	LEASED OFFICE SPACE	0	1,278,967	0	1,278,967		194.06
194.08	07958	MISC NONREIMBURSABLE COST CENTERS	0	2,206,413	0	2,206,413		194.08
200.00		Cross Foot Adjustments	0	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	1,668,729	236,206,861	-2,374,635	233,832,226		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0128 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II Date/Time Prepared: 5/24/2024 11:48 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	382,175	2,442,842	2,825,017	0	5.00
7.00	00700	OPERATION OF PLANT	0	993,324	37,875	1,031,199	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	20,681	0	20,681	0	8.00
9.00	00900	HOUSEKEEPING	0	43,867	15,963	59,830	0	9.00
10.00	01000	DIETARY	0	78,362	6,126	84,488	0	10.00
11.00	01100	CAFETERIA	0	168,379	18,650	187,029	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	8,639	0	8,639	0	16.00
17.00	01700	SOCIAL SERVICE	0	20,375	1,806	22,181	0	17.00
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
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	1,743,271	210,736	1,954,007	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	552,144	83,933	636,077	0	31.00
43.00	04300	NURSERY	0	57,926	17,612	75,538	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	777,430	1,561,357	2,338,787	0	50.00
51.00	05100	RECOVERY ROOM	0	160,861	70,255	231,116	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	295,805	89,935	385,740	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	259,986	255,250	515,236	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	187,956	187,956	0	55.00
57.00	05700	CT SCAN	0	34,923	10,175	45,098	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	31,867	169,669	201,536	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	209,863	465,519	675,382	0	59.00
60.00	06000	LABORATORY	0	99,206	0	99,206	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	70,803	68,321	139,124	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	48,268	35,048	83,316	0	65.00
66.00	06600	PHYSICAL THERAPY	0	15,893	505,932	521,825	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	4,584	20,387	24,971	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	958	4,292	5,250	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	113,672	188,621	302,293	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	47,331	142,680	190,011	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	220,254	1,449,807	1,670,061	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	119,805	411,604	531,409	0	73.00
74.00	07400	RENAL DIALYSIS	0	21,944	13,124	35,068	0	74.00
76.00	03950	ENDOSCOPY	0	0	158,168	158,168	0	76.00
76.06	03330	IMAGING CENTER	0	0	471,584	471,584	0	76.06
76.97	07697	CARDIAC REHABILITATION	0	0	19,749	19,749	0	76.97
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	04950	DIABETIC CARE CENTER	0	0	0	0	0	90.01
90.02	04951	ANTI-COAGULATION CLINIC	0	0	706	706	0	90.02
90.03	04952	PALLIATIVE CARE	0	0	0	0	0	90.03
90.04	04953	SPINE CENTER	0	0	72,324	72,324	0	90.04
91.00	09100	EMERGENCY	0	565,958	98,810	664,768	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	7,168,554	9,306,816	16,475,370	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	23,941	0	23,941	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	HOME OFFICE	0	0	0	0	0	194.00
194.06	07956	LEASED OFFICE SPACE	0	380,545	0	380,545	0	194.06
194.08	07958	MISC NONREIMBURSABLE COST CENTERS	0	11,104	0	11,104	0	194.08
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	7,584,144	9,306,816	16,890,960	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0128 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II | Date/Time Prepared: 5/24/2024 11:48 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,825,017					5.00
7.00	00700	OPERATION OF PLANT	112,945	1,144,144				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	10,708	3,811	35,200			8.00
9.00	00900	HOUSEKEEPING	44,275	8,084	0	112,189		9.00
10.00	01000	DIETARY	18,263	14,441	0	1,431	118,623	10.00
11.00	01100	CAFETERIA	18,092	31,029	0	3,075	0	11.00
13.00	01300	NURSING ADMINISTRATION	38,555	0	0	0	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	22,483	1,592	0	158	0	16.00
17.00	01700	SOCIAL SERVICE	30,473	3,755	0	372	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	8,442	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	19,958	0	0	0	0	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	570,774	321,253	14,167	31,830	108,345	30.00
31.00	03100	INTENSIVE CARE UNIT	86,048	101,750	1,692	10,082	10,278	31.00
43.00	04300	NURSERY	15,970	10,675	282	1,058	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	155,068	143,267	3,933	14,196	0	50.00
51.00	05100	RECOVERY ROOM	77,580	29,644	1,752	2,937	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	91,726	54,512	1,440	5,401	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54,844	47,911	631	4,747	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	27,991	0	0	0	0	55.00
57.00	05700	CT SCAN	38,659	6,436	2,425	638	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	18,206	5,872	0	582	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	60,607	38,674	425	3,832	0	59.00
60.00	06000	LABORATORY	142,383	18,282	0	1,811	0	60.00
64.00	06400	INTRAVENOUS THERAPY	26,277	13,048	0	1,293	0	64.00
65.00	06500	RESPIRATORY THERAPY	51,079	8,895	0	881	0	65.00
66.00	06600	PHYSICAL THERAPY	62,100	2,929	0	290	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	16,112	845	0	84	0	67.00
68.00	06800	SPEECH PATHOLOGY	3,392	176	0	17	0	68.00
69.00	06900	ELECTROCARDIOLOGY	35,397	20,948	0	2,076	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	17,119	8,722	0	864	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	288,040	40,589	0	4,022	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	171,597	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	192,863	22,078	0	2,188	0	73.00
74.00	07400	RENAL DIALYSIS	14,333	4,044	0	401	0	74.00
76.00	03950	ENDOSCOPY	17,809	0	0	0	0	76.00
76.06	03330	IMAGING CENTER	33,204	0	0	0	0	76.06
76.97	07697	CARDIAC REHABILITATION	7,882	0	0	0	0	76.97
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	04950	DIABETIC CARE CENTER	0	0	0	0	0	90.01
90.02	04951	ANTI-COAGULATION CLINIC	6,406	0	0	0	0	90.02
90.03	04952	PALLIATIVE CARE	0	0	0	0	0	90.03
90.04	04953	SPINE CENTER	4,969	0	0	0	0	90.04
91.00	09100	EMERGENCY	178,776	104,296	8,453	10,334	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)	2,791,405	1,067,558	35,200	104,600	118,623	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	351	4,412	0	437	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,574	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	HOME OFFICE	0	0	0	0	0	194.00
194.06	07956	LEASED OFFICE SPACE	5,582	70,128	0	6,949	0	194.06
194.08	07958	MISC NONREIMBURSABLE COST CENTERS	26,105	2,046	0	203	0	194.08
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	2,825,017	1,144,144	35,200	112,189	118,623	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0128 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II Date/Time Prepared: 5/24/2024 11:48 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES	
			11.00	13.00	16.00	17.00	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
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	239,225					11.00
13.00	01300	NURSING ADMINISTRATION	2,855	41,410				13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	32,872			16.00
17.00	01700	SOCIAL SERVICE	5,394	0	0	62,175		17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	8,442	21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	0	0	0	0		22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	90,422	29,354	3,773	54,042		30.00
31.00	03100	INTENSIVE CARE UNIT	10,153	3,306	460	4,909		31.00
43.00	04300	NURSERY	1,904	637	100	3,224		43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	14,912	0	4,218	0		50.00
51.00	05100	RECOVERY ROOM	11,422	0	1,048	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	10,153	0	509	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,980	0	1,189	0		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	2,855	0	741	0		55.00
57.00	05700	CT SCAN	4,442	0	2,695	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	2,221	0	519	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	5,076	0	3,440	0		59.00
60.00	06000	LABORATORY	0	0	1,681	0		60.00
64.00	06400	INTRAVENOUS THERAPY	2,855	0	87	0		64.00
65.00	06500	RESPIRATORY THERAPY	7,615	0	602	0		65.00
66.00	06600	PHYSICAL THERAPY	4,125	0	339	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	2,855	0	102	0		67.00
68.00	06800	SPEECH PATHOLOGY	635	0	21	0		68.00
69.00	06900	ELECTROCARDIOLOGY	6,028	0	809	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,904	0	179	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,490	0	1,162	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	960	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	10,787	0	1,653	0		73.00
74.00	07400	RENAL DIALYSIS	1,269	0	59	0		74.00
76.00	03950	ENDOSCOPY	1,904	0	280	0		76.00
76.06	03330	IMAGING CENTER	0	0	588	0		76.06
76.97	07697	CARDIAC REHABILITATION	1,904	0	70	0		76.97
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	04950	DIABETIC CARE CENTER	0	0	0	0		90.01
90.02	04951	ANTI-COAGULATION CLINIC	0	0	63	0		90.02
90.03	04952	PALLIATIVE CARE	0	0	0	0		90.03
90.04	04953	SPINE CENTER	0	0	10	0		90.04
91.00	09100	EMERGENCY	25,065	8,113	5,515	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		102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	239,225	41,410	32,872	62,175	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
191.00	19100	RESEARCH	0	0	0	0		191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192.00
193.00	19300	NONPAID WORKERS	0	0	0	0		193.00
194.00	07950	HOME OFFICE	0	0	0	0		194.00
194.06	07956	LEASED OFFICE SPACE	0	0	0	0		194.06
194.08	07958	MISC NONREIMBURSABLE COST CENTERS	0	0	0	0		194.08
200.00		Cross Foot Adjustments					8,442	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	239,225	41,410	32,872	62,175	8,442	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0128 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II | Date/Time Prepared: 5/24/2024 11:48 am

		Cost Center Description	INTERNS & RESIDENTS SERVICES-OTHER PRGM. COSTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			22.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE						17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD						21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	19,958					22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS		3,177,967	0	3,177,967		30.00
31.00	03100	INTENSIVE CARE UNIT		864,755	0	864,755		31.00
43.00	04300	NURSERY		109,388	0	109,388		43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM		2,674,381	0	2,674,381		50.00
51.00	05100	RECOVERY ROOM		355,499	0	355,499		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		549,481	0	549,481		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		631,538	0	631,538		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC		219,543	0	219,543		55.00
57.00	05700	CT SCAN		100,393	0	100,393		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)		228,936	0	228,936		58.00
59.00	05900	CARDIAC CATHETERIZATION		787,436	0	787,436		59.00
60.00	06000	LABORATORY		263,363	0	263,363		60.00
64.00	06400	INTRAVENOUS THERAPY		182,684	0	182,684		64.00
65.00	06500	RESPIRATORY THERAPY		152,388	0	152,388		65.00
66.00	06600	PHYSICAL THERAPY		591,608	0	591,608		66.00
67.00	06700	OCCUPATIONAL THERAPY		44,969	0	44,969		67.00
68.00	06800	SPEECH PATHOLOGY		9,491	0	9,491		68.00
69.00	06900	ELECTROCARDIOLOGY		367,551	0	367,551		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY		218,799	0	218,799		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		2,007,364	0	2,007,364		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		172,557	0	172,557		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		760,978	0	760,978		73.00
74.00	07400	RENAL DIALYSIS		55,174	0	55,174		74.00
76.00	03950	ENDOSCOPY		178,161	0	178,161		76.00
76.06	03330	IMAGING CENTER		505,376	0	505,376		76.06
76.97	07697	CARDIAC REHABILITATION		29,605	0	29,605		76.97
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	04950	DIABETIC CARE CENTER		0	0	0		90.01
90.02	04951	ANTI-COAGULATION CLINIC		7,175	0	7,175		90.02
90.03	04952	PALLIATIVE CARE		0	0	0		90.03
90.04	04953	SPINE CENTER		77,303	0	77,303		90.04
91.00	09100	EMERGENCY		1,005,320	0	1,005,320		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM		0	0	0		102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	16,329,183	0	16,329,183		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN		29,141	0	29,141		190.00
191.00	19100	RESEARCH		0	0	0		191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES		1,574	0	1,574		192.00
193.00	19300	NONPAID WORKERS		0	0	0		193.00
194.00	07950	HOME OFFICE		0	0	0		194.00
194.06	07956	LEASED OFFICE SPACE		463,204	0	463,204		194.06
194.08	07958	MISC NONREIMBURSABLE COST CENTERS		39,458	0	39,458		194.08
200.00		Cross Foot Adjustments	19,958	28,400	0	28,400		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	19,958	16,890,960	0	16,890,960		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0128 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/24/2024 11:48 am

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	372,227					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		9,488,056				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	83,824,151			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	18,757	2,490,410	4,331,573	-43,611,621	192,595,240	5.00
7.00	00700	OPERATION OF PLANT	48,752	38,613	846,626	0	7,700,072	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,015	0	0	0	730,047	8.00
9.00	00900	HOUSEKEEPING	2,153	16,274	1,660,845	0	3,018,471	9.00
10.00	01000	DIETARY	3,846	6,245	483,143	0	1,245,112	10.00
11.00	01100	CAFETERIA	8,264	19,013	1,043,379	0	1,233,402	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	376,046	0	2,628,511	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	424	0	0	0	1,532,761	16.00
17.00	01700	SOCIAL SERVICE	1,000	1,841	1,535,285	0	2,077,502	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	575,572	21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	0	0	0	0	1,360,626	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	85,559	214,840	27,655,812	0	38,910,899	30.00
31.00	03100	INTENSIVE CARE UNIT	27,099	85,568	3,805,838	0	5,866,380	31.00
43.00	04300	NURSERY	2,843	17,955	590,276	0	1,088,769	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	38,156	1,591,763	3,772,186	0	10,571,847	50.00
51.00	05100	RECOVERY ROOM	7,895	71,623	3,550,185	0	5,289,058	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	14,518	91,686	3,655,865	0	6,253,464	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	12,760	260,221	1,962,185	0	3,739,035	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	191,616	876,542	0	1,908,290	55.00
57.00	05700	CT SCAN	1,714	10,373	1,256,834	0	2,635,583	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,564	172,973	674,827	0	1,241,236	58.00
59.00	05900	CARDIAC CATHETERIZATION	10,300	474,585	1,641,966	0	4,131,918	59.00
60.00	06000	LABORATORY	4,869	0	0	0	9,707,042	60.00
64.00	06400	INTRAVENOUS THERAPY	3,475	69,651	655,326	0	1,791,476	64.00
65.00	06500	RESPIRATORY THERAPY	2,369	35,731	2,464,550	0	3,482,323	65.00
66.00	06600	PHYSICAL THERAPY	780	515,785	2,676,010	0	4,233,722	66.00
67.00	06700	OCCUPATIONAL THERAPY	225	20,784	781,836	0	1,098,421	67.00
68.00	06800	SPEECH PATHOLOGY	47	4,376	164,609	0	231,256	68.00
69.00	06900	ELECTROCARDIOLOGY	5,579	192,294	1,298,190	0	2,413,213	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	2,323	145,459	541,365	0	1,167,090	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	10,810	1,478,041	587,227	0	19,637,294	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	11,698,761	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,880	419,620	3,639,581	0	13,148,578	73.00
74.00	07400	RENAL DIALYSIS	1,077	13,380	533,815	0	977,194	74.00
76.00	03950	ENDOSCOPY	0	161,248	656,255	0	1,214,130	76.00
76.06	03330	IMAGING CENTER	0	480,768	1,098,695	0	2,263,677	76.06
76.97	07697	CARDIAC REHABILITATION	0	20,134	388,416	0	537,327	76.97
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	04950	DIABETIC CARE CENTER	0	0	0	0	0	90.01
90.02	04951	ANTI-COAGULATION CLINIC	0	720	613,608	0	436,745	90.02
90.03	04952	PALLIATIVE CARE	0	0	0	0	0	90.03
90.04	04953	SPINE CENTER	0	73,732	182,574	0	338,747	90.04
91.00	09100	EMERGENCY	27,777	100,734	6,841,165	0	12,188,195	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)	351,830	9,488,056	82,842,635	-43,611,621	190,303,746	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,175	0	0	0	23,941	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	107,297	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	HOME OFFICE	0	0	0	0	0	194.00
194.06	07956	LEASED OFFICE SPACE	18,677	0	0	0	380,545	194.06
194.08	07958	MISC NONREIMBURSABLE COST CENTERS	545	0	981,516	0	1,779,711	194.08
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	7,584,144	9,306,816	3,461,945		43,611,621	202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0128 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/24/2024 11:48 am

	Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
		1.00	2.00	4.00	5A	5.00	
203.00	Unit cost multiplier (Wkst. B, Part I)	20.375051	0.980898	0.041300		0.226442	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)			0		2,825,017	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)			0.000000		0.014668	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: 15-0128 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/24/2024 11:48 am

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DAYS)	CAFETERIA (ONSITE FTES)	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	304,718					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,015	82,514				8.00
9.00	00900	HOUSEKEEPING	2,153	0	301,550			9.00
10.00	01000	DIETARY	3,846	0	3,846	36,885		10.00
11.00	01100	CAFETERIA	8,264	0	8,264	0	754	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	9	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	424	0	424	0	0	16.00
17.00	01700	SOCIAL SERVICE	1,000	0	1,000	0	17	17.00
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
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	85,559	33,211	85,559	33,689	285	30.00
31.00	03100	INTENSIVE CARE UNIT	27,099	3,967	27,099	3,196	32	31.00
43.00	04300	NURSERY	2,843	661	2,843	0	6	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	38,156	9,219	38,156	0	47	50.00
51.00	05100	RECOVERY ROOM	7,895	4,107	7,895	0	36	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	14,518	3,375	14,518	0	32	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	12,760	1,478	12,760	0	22	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	9	55.00
57.00	05700	CT SCAN	1,714	5,684	1,714	0	14	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,564	0	1,564	0	7	58.00
59.00	05900	CARDIAC CATHETERIZATION	10,300	996	10,300	0	16	59.00
60.00	06000	LABORATORY	4,869	0	4,869	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	3,475	0	3,475	0	9	64.00
65.00	06500	RESPIRATORY THERAPY	2,369	0	2,369	0	24	65.00
66.00	06600	PHYSICAL THERAPY	780	0	780	0	13	66.00
67.00	06700	OCCUPATIONAL THERAPY	225	0	225	0	9	67.00
68.00	06800	SPEECH PATHOLOGY	47	0	47	0	2	68.00
69.00	06900	ELECTROCARDIOLOGY	5,579	0	5,579	0	19	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	2,323	0	2,323	0	6	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	10,810	0	10,810	0	11	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,880	0	5,880	0	34	73.00
74.00	07400	RENAL DIALYSIS	1,077	0	1,077	0	4	74.00
76.00	03950	ENDOSCOPY	0	0	0	0	6	76.00
76.06	03330	IMAGING CENTER	0	0	0	0	0	76.06
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	6	76.97
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	04950	DIABETIC CARE CENTER	0	0	0	0	0	90.01
90.02	04951	ANTI-COAGULATION CLINIC	0	0	0	0	0	90.02
90.03	04952	PALLIATIVE CARE	0	0	0	0	0	90.03
90.04	04953	SPINE CENTER	0	0	0	0	0	90.04
91.00	09100	EMERGENCY	27,777	19,816	27,777	0	79	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)	284,321	82,514	281,153	36,885	754	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,175	0	1,175	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	HOME OFFICE	0	0	0	0	0	194.00
194.06	07956	LEASED OFFICE SPACE	18,677	0	18,677	0	0	194.06
194.08	07958	MISC NONREIMBURSABLE COST CENTERS	545	0	545	0	0	194.08
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)	9,443,692	926,816	3,768,705	1,694,318	1,872,092	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	30.991579	11.232227	12.497778	45.935150	2,482.880637	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	1,144,144	35,200	112,189	118,623	239,225	204.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0128 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/24/2024 11:48 am

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DAYS)	CAFETERIA (ONSITE FTES)	
			7.00	8.00	9.00	10.00	11.00	
205.00		Unit cost multiplier (Wkst. B, Part II)	3.754763	0.426594	0.372041	3.216023	317.274536	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: 15-0128 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/24/2024 11:48 am

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TOTAL PATIENT DAYS)	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES (ASSIGNED TIME)	INTERNS & RESIDENTS SERVICES-OTHER PRGM. COSTS (ASSIGNED TIME)	
			13.00	16.00	17.00	21.00	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
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	837,144					13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,210,165,914				16.00
17.00	01700	SOCIAL SERVICE	0	0	40,476			17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	64,600		21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	0	0	0		64,600	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	593,428	139,757,782	35,181	35,800	35,800	30.00
31.00	03100	INTENSIVE CARE UNIT	66,838	17,054,170	3,196	4,100	4,100	31.00
43.00	04300	NURSERY	12,876	3,692,817	2,099	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	156,204,355	0	15,300	15,300	50.00
51.00	05100	RECOVERY ROOM	0	38,817,562	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	18,856,638	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	44,053,195	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	27,435,148	0	0	0	55.00
57.00	05700	CT SCAN	0	99,803,409	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	19,216,261	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	127,390,768	0	1,700	1,700	59.00
60.00	06000	LABORATORY	0	62,249,445	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	3,232,970	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	22,303,959	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	12,551,986	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	3,782,392	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	796,037	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	29,949,920	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	6,624,693	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	43,038,948	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	35,544,813	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	61,221,347	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	2,183,962	0	0	0	74.00
76.00	03950	ENDOSCOPY	0	10,380,687	0	0	0	76.00
76.06	03330	IMAGING CENTER	0	21,774,419	0	0	0	76.06
76.97	07697	CARDIAC REHABILITATION	0	2,598,061	0	0	0	76.97
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	04950	DIABETIC CARE CENTER	0	0	0	0	0	90.01
90.02	04951	ANTI-COAGULATION CLINIC	0	2,340,778	0	0	0	90.02
90.03	04952	PALLIATIVE CARE	0	0	0	0	0	90.03
90.04	04953	SPINE CENTER	0	386,566	0	400	400	90.04
91.00	09100	EMERGENCY	164,002	196,922,826	0	7,300	7,300	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)	837,144	1,210,165,914	40,476	64,600	64,600	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	HOME OFFICE	0	0	0	0	0	194.00
194.06	07956	LEASED OFFICE SPACE	0	0	0	0	0	194.06
194.08	07958	MISC NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.08
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	3,246,062	1,898,281	2,633,635	705,906	1,668,729	202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0128 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/24/2024 11:48 am

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TOTAL PATIENT DAYS)	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES (ASSIGNED TIME)	INTERNS & RESIDENTS SERVICES-OTHER PRGM. COSTS (ASSIGNED TIME)	
			13.00	16.00	17.00	21.00	22.00	
203.00		Unit cost multiplier (Wkst. B, Part I)	3.877543	0.001569	65.066583	10.927337	25.831718	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	41,410	32,872	62,175	8,442	19,958	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.049466	0.000027	1.536095	0.130681	0.308947	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0128 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 5/24/2024 11:48 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	58,880,430		58,880,430	0	58,880,430	30.00
31.00	03100	INTENSIVE CARE UNIT	9,137,990		9,137,990	0	9,137,990	31.00
43.00	04300	NURSERY	1,673,570		1,673,570	0	1,673,570	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	15,090,467		15,090,467	0	15,090,467	50.00
51.00	05100	RECOVERY ROOM	7,026,492		7,026,492	0	7,026,492	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	8,447,837		8,447,837	0	8,447,837	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,280,978		5,280,978	0	5,280,978	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	2,405,799		2,405,799	0	2,405,799	55.00
57.00	05700	CT SCAN	3,562,127		3,562,127	0	3,562,127	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,637,852		1,637,852	0	1,637,852	58.00
59.00	05900	CARDIAC CATHETERIZATION	5,766,287		5,766,287	0	5,766,287	59.00
60.00	06000	LABORATORY	12,214,543		12,214,543	0	12,214,543	60.00
64.00	06400	INTRAVENOUS THERAPY	2,375,686		2,375,686	0	2,375,686	64.00
65.00	06500	RESPIRATORY THERAPY	4,468,477	0	4,468,477	0	4,468,477	65.00
66.00	06600	PHYSICAL THERAPY	5,278,306	0	5,278,306	0	5,278,306	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,385,216	0	1,385,216	0	1,385,216	67.00
68.00	06800	SPEECH PATHOLOGY	291,881	0	291,881	0	291,881	68.00
69.00	06900	ELECTROCARDIOLOGY	3,296,459		3,296,459	0	3,296,459	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,557,684		1,557,684	0	1,557,684	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	24,648,962		24,648,962	0	24,648,962	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	14,403,622		14,403,622	0	14,403,622	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	16,562,159		16,562,159	0	16,562,159	73.00
74.00	07400	RENAL DIALYSIS	1,258,669		1,258,669	0	1,258,669	74.00
76.00	03950	ENDOSCOPY	1,520,244		1,520,244	0	1,520,244	76.00
76.06	03330	IMAGING CENTER	2,810,433		2,810,433	0	2,810,433	76.06
76.97	07697	CARDIAC REHABILITATION	677,973		677,973	0	677,973	76.97
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	04950	DIABETIC CARE CENTER	0		0	0	0	90.01
90.02	04951	ANTI-COAGULATION CLINIC	539,315		539,315	0	539,315	90.02
90.03	04952	PALLIATIVE CARE	0		0	0	0	90.03
90.04	04953	SPINE CENTER	416,061		416,061	0	416,061	90.04
91.00	09100	EMERGENCY	17,519,271		17,519,271	0	17,519,271	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	9,384,090		9,384,090		9,384,090	92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0		0		0	102.00
200.00		Subtotal (see instructions)	239,518,880	0	239,518,880	0	239,518,880	200.00
201.00		Less Observation Beds	9,384,090		9,384,090		9,384,090	201.00
202.00		Total (see instructions)	230,134,790	0	230,134,790	0	230,134,790	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0128 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I | Date/Time Prepared: 5/24/2024 11:48 am

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		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	126,895,090		126,895,090			30.00
31.00	03100	INTENSIVE CARE UNIT	17,054,170		17,054,170			31.00
43.00	04300	NURSERY	3,692,817		3,692,817			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	70,213,357	85,990,998	156,204,355	0.096607	0.000000	50.00
51.00	05100	RECOVERY ROOM	11,316,055	27,501,507	38,817,562	0.181013	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	18,856,638	0	18,856,638	0.448003	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,086,013	35,967,182	44,053,195	0.119877	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	11,272,655	16,162,493	27,435,148	0.087690	0.000000	55.00
57.00	05700	CT SCAN	24,128,863	75,674,546	99,803,409	0.035691	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	3,830,153	15,386,108	19,216,261	0.085233	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	43,127,057	84,263,711	127,390,768	0.045265	0.000000	59.00
60.00	06000	LABORATORY	32,247,071	30,002,374	62,249,445	0.196219	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	289,811	2,943,159	3,232,970	0.734831	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	18,814,851	3,489,108	22,303,959	0.200345	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	2,799,329	9,752,657	12,551,986	0.420516	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,381,518	1,400,874	3,782,392	0.366228	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	569,652	226,385	796,037	0.366668	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	7,404,127	22,545,793	29,949,920	0.110066	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	463,942	6,160,751	6,624,693	0.235133	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	21,385,239	21,653,709	43,038,948	0.572713	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	16,159,912	19,384,901	35,544,813	0.405224	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	39,424,531	21,796,816	61,221,347	0.270529	0.000000	73.00
74.00	07400	RENAL DIALYSIS	2,183,962	0	2,183,962	0.576324	0.000000	74.00
76.00	03950	ENDOSCOPY	2,919,521	7,461,166	10,380,687	0.146449	0.000000	76.00
76.06	03330	IMAGING CENTER	103,879	21,670,540	21,774,419	0.129070	0.000000	76.06
76.97	07697	CARDIAC REHABILITATION	6,463	2,591,598	2,598,061	0.260953	0.000000	76.97
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	04950	DIABETIC CARE CENTER	0	0	0	0.000000	0.000000	90.01
90.02	04951	ANTI-COAGULATION CLINIC	10,688	2,330,090	2,340,778	0.230400	0.000000	90.02
90.03	04952	PALLIATIVE CARE	0	0	0	0.000000	0.000000	90.03
90.04	04953	SPINE CENTER	0	386,566	386,566	1.076300	0.000000	90.04
91.00	09100	EMERGENCY	39,773,503	157,149,323	196,922,826	0.088965	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,194,117	10,668,575	12,862,692	0.729559	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0			102.00
200.00		Subtotal (see instructions)	527,604,984	682,560,930	1,210,165,914			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	527,604,984	682,560,930	1,210,165,914			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0128 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 5/24/2024 11:48 am

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		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	0.096607		50.00
51.00	05100	RECOVERY ROOM	0.181013		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.448003		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.119877		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.087690		55.00
57.00	05700	CT SCAN	0.035691		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.085233		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.045265		59.00
60.00	06000	LABORATORY	0.196219		60.00
64.00	06400	INTRAVENOUS THERAPY	0.734831		64.00
65.00	06500	RESPIRATORY THERAPY	0.200345		65.00
66.00	06600	PHYSICAL THERAPY	0.420516		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.366228		67.00
68.00	06800	SPEECH PATHOLOGY	0.366668		68.00
69.00	06900	ELECTROCARDIOLOGY	0.110066		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.235133		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.572713		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.405224		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.270529		73.00
74.00	07400	RENAL DIALYSIS	0.576324		74.00
76.00	03950	ENDOSCOPY	0.146449		76.00
76.06	03330	IMAGING CENTER	0.129070		76.06
76.97	07697	CARDIAC REHABILITATION	0.260953		76.97
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	04950	DIABETIC CARE CENTER	0.000000		90.01
90.02	04951	ANTI-COAGULATION CLINIC	0.230400		90.02
90.03	04952	PALLIATIVE CARE	0.000000		90.03
90.04	04953	SPINE CENTER	1.076300		90.04
91.00	09100	EMERGENCY	0.088965		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.729559		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: 15-0128 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 5/24/2024 11:48 am

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		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	60,196,404		60,196,404	0	60,196,404	30.00
31.00	03100	INTENSIVE CARE UNIT	9,288,702		9,288,702	0	9,288,702	31.00
43.00	04300	NURSERY	1,673,570		1,673,570	0	1,673,570	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	15,652,880		15,652,880	0	15,652,880	50.00
51.00	05100	RECOVERY ROOM	7,026,492		7,026,492	0	7,026,492	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	8,447,837		8,447,837	0	8,447,837	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,280,978		5,280,978	0	5,280,978	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	2,405,799		2,405,799	0	2,405,799	55.00
57.00	05700	CT SCAN	3,562,127		3,562,127	0	3,562,127	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,637,852		1,637,852	0	1,637,852	58.00
59.00	05900	CARDIAC CATHETERIZATION	5,828,777		5,828,777	0	5,828,777	59.00
60.00	06000	LABORATORY	12,214,543		12,214,543	0	12,214,543	60.00
64.00	06400	INTRAVENOUS THERAPY	2,375,686		2,375,686	0	2,375,686	64.00
65.00	06500	RESPIRATORY THERAPY	4,468,477	0	4,468,477	0	4,468,477	65.00
66.00	06600	PHYSICAL THERAPY	5,278,306	0	5,278,306	0	5,278,306	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,385,216	0	1,385,216	0	1,385,216	67.00
68.00	06800	SPEECH PATHOLOGY	291,881	0	291,881	0	291,881	68.00
69.00	06900	ELECTROCARDIOLOGY	3,296,459		3,296,459	0	3,296,459	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,557,684		1,557,684	0	1,557,684	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	24,648,962		24,648,962	0	24,648,962	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	14,403,622		14,403,622	0	14,403,622	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	16,562,159		16,562,159	0	16,562,159	73.00
74.00	07400	RENAL DIALYSIS	1,258,669		1,258,669	0	1,258,669	74.00
76.00	03950	ENDOSCOPY	1,520,244		1,520,244	0	1,520,244	76.00
76.06	03330	IMAGING CENTER	2,810,433		2,810,433	0	2,810,433	76.06
76.97	07697	CARDIAC REHABILITATION	677,973		677,973	0	677,973	76.97
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	04950	DIABETIC CARE CENTER	0		0	0	0	90.01
90.02	04951	ANTI-COAGULATION CLINIC	539,315		539,315	0	539,315	90.02
90.03	04952	PALLIATIVE CARE	0		0	0	0	90.03
90.04	04953	SPINE CENTER	430,765		430,765	0	430,765	90.04
91.00	09100	EMERGENCY	17,787,613		17,787,613	0	17,787,613	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	9,384,090		9,384,090		9,384,090	92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0		0		0	102.00
200.00		Subtotal (see instructions)	241,893,515	0	241,893,515	0	241,893,515	200.00
201.00		Less Observation Beds	9,384,090		9,384,090		9,384,090	201.00
202.00		Total (see instructions)	232,509,425	0	232,509,425	0	232,509,425	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0128 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I | Date/Time Prepared: 5/24/2024 11:48 am

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		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	126,895,090		126,895,090			30.00
31.00	03100	INTENSIVE CARE UNIT	17,054,170		17,054,170			31.00
43.00	04300	NURSERY	3,692,817		3,692,817			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	70,213,357	85,990,998	156,204,355	0.100208	0.000000	50.00
51.00	05100	RECOVERY ROOM	11,316,055	27,501,507	38,817,562	0.181013	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	18,856,638	0	18,856,638	0.448003	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,086,013	35,967,182	44,053,195	0.119877	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	11,272,655	16,162,493	27,435,148	0.087690	0.000000	55.00
57.00	05700	CT SCAN	24,128,863	75,674,546	99,803,409	0.035691	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	3,830,153	15,386,108	19,216,261	0.085233	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	43,127,057	84,263,711	127,390,768	0.045755	0.000000	59.00
60.00	06000	LABORATORY	32,247,071	30,002,374	62,249,445	0.196219	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	289,811	2,943,159	3,232,970	0.734831	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	18,814,851	3,489,108	22,303,959	0.200345	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	2,799,329	9,752,657	12,551,986	0.420516	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,381,518	1,400,874	3,782,392	0.366228	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	569,652	226,385	796,037	0.366668	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	7,404,127	22,545,793	29,949,920	0.110066	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	463,942	6,160,751	6,624,693	0.235133	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	21,385,239	21,653,709	43,038,948	0.572713	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	16,159,912	19,384,901	35,544,813	0.405224	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	39,424,531	21,796,816	61,221,347	0.270529	0.000000	73.00
74.00	07400	RENAL DIALYSIS	2,183,962	0	2,183,962	0.576324	0.000000	74.00
76.00	03950	ENDOSCOPY	2,919,521	7,461,166	10,380,687	0.146449	0.000000	76.00
76.06	03330	IMAGING CENTER	103,879	21,670,540	21,774,419	0.129070	0.000000	76.06
76.97	07697	CARDIAC REHABILITATION	6,463	2,591,598	2,598,061	0.260953	0.000000	76.97
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	04950	DIABETIC CARE CENTER	0	0	0	0.000000	0.000000	90.01
90.02	04951	ANTI-COAGULATION CLINIC	10,688	2,330,090	2,340,778	0.230400	0.000000	90.02
90.03	04952	PALLIATIVE CARE	0	0	0	0.000000	0.000000	90.03
90.04	04953	SPINE CENTER	0	386,566	386,566	1.114338	0.000000	90.04
91.00	09100	EMERGENCY	39,773,503	157,149,323	196,922,826	0.090328	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,194,117	10,668,575	12,862,692	0.729559	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0			102.00
200.00		Subtotal (see instructions)	527,604,984	682,560,930	1,210,165,914			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	527,604,984	682,560,930	1,210,165,914			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0128 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 5/24/2024 11:48 am

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		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	0.100208	50.00
51.00	05100	RECOVERY ROOM	0.181013	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.448003	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.119877	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.087690	55.00
57.00	05700	CT SCAN	0.035691	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.085233	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.045755	59.00
60.00	06000	LABORATORY	0.196219	60.00
64.00	06400	INTRAVENOUS THERAPY	0.734831	64.00
65.00	06500	RESPIRATORY THERAPY	0.200345	65.00
66.00	06600	PHYSICAL THERAPY	0.420516	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.366228	67.00
68.00	06800	SPEECH PATHOLOGY	0.366668	68.00
69.00	06900	ELECTROCARDIOLOGY	0.110066	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.235133	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.572713	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.405224	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.270529	73.00
74.00	07400	RENAL DIALYSIS	0.576324	74.00
76.00	03950	ENDOSCOPY	0.146449	76.00
76.06	03330	IMAGING CENTER	0.129070	76.06
76.97	07697	CARDIAC REHABILITATION	0.260953	76.97
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	04950	DIABETIC CARE CENTER	0.000000	90.01
90.02	04951	ANTI-COAGULATION CLINIC	0.230400	90.02
90.03	04952	PALLIATIVE CARE	0.000000	90.03
90.04	04953	SPINE CENTER	1.114338	90.04
91.00	09100	EMERGENCY	0.090328	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.729559	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: 15-0128 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part II | Date/Time Prepared: 5/24/2024 11:48 am

Title XIX | Hospital | PPS

		Cost Center Description	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	15,652,880	2,674,381	12,978,499	0	0	50.00
51.00	05100	RECOVERY ROOM	7,026,492	355,499	6,670,993	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	8,447,837	549,481	7,898,356	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,280,978	631,538	4,649,440	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	2,405,799	219,543	2,186,256	0	0	55.00
57.00	05700	CT SCAN	3,562,127	100,393	3,461,734	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,637,852	228,936	1,408,916	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	5,828,777	787,436	5,041,341	0	0	59.00
60.00	06000	LABORATORY	12,214,543	263,363	11,951,180	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	2,375,686	182,684	2,193,002	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	4,468,477	152,388	4,316,089	0	0	65.00
66.00	06600	PHYSICAL THERAPY	5,278,306	591,608	4,686,698	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,385,216	44,969	1,340,247	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	291,881	9,491	282,390	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	3,296,459	367,551	2,928,908	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,557,684	218,799	1,338,885	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	24,648,962	2,007,364	22,641,598	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	14,403,622	172,557	14,231,065	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	16,562,159	760,978	15,801,181	0	0	73.00
74.00	07400	RENAL DIALYSIS	1,258,669	55,174	1,203,495	0	0	74.00
76.00	03950	ENDOSCOPY	1,520,244	178,161	1,342,083	0	0	76.00
76.06	03330	IMAGING CENTER	2,810,433	505,376	2,305,057	0	0	76.06
76.97	07697	CARDIAC REHABILITATION	677,973	29,605	648,368	0	0	76.97
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	04950	DIABETIC CARE CENTER	0	0	0	0	0	90.01
90.02	04951	ANTI-COAGULATION CLINIC	539,315	7,175	532,140	0	0	90.02
90.03	04952	PALLIATIVE CARE	0	0	0	0	0	90.03
90.04	04953	SPINE CENTER	430,765	77,303	353,462	0	0	90.04
91.00	09100	EMERGENCY	17,787,613	1,005,320	16,782,293	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	9,384,090	506,487	8,877,603	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)	170,734,839	12,683,560	158,051,279	0	0	200.00
201.00		Less Observation Beds	9,384,090	506,487	8,877,603	0	0	201.00
202.00		Total (line 200 minus line 201)	161,350,749	12,177,073	149,173,676	0	0	202.00

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

Provider CCN: 15-0128 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part II | Date/Time Prepared: 5/24/2024 11:48 am

Title XIX | Hospital | PPS

		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)		
			6.00	7.00	8.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	15,652,880	156,204,355	0.100208		50.00
51.00	05100	RECOVERY ROOM	7,026,492	38,817,562	0.181013		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	8,447,837	18,856,638	0.448003		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,280,978	44,053,195	0.119877		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	2,405,799	27,435,148	0.087690		55.00
57.00	05700	CT SCAN	3,562,127	99,803,409	0.035691		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,637,852	19,216,261	0.085233		58.00
59.00	05900	CARDIAC CATHETERIZATION	5,828,777	127,390,768	0.045755		59.00
60.00	06000	LABORATORY	12,214,543	62,249,445	0.196219		60.00
64.00	06400	INTRAVENOUS THERAPY	2,375,686	3,232,970	0.734831		64.00
65.00	06500	RESPIRATORY THERAPY	4,468,477	22,303,959	0.200345		65.00
66.00	06600	PHYSICAL THERAPY	5,278,306	12,551,986	0.420516		66.00
67.00	06700	OCCUPATIONAL THERAPY	1,385,216	3,782,392	0.366228		67.00
68.00	06800	SPEECH PATHOLOGY	291,881	796,037	0.366668		68.00
69.00	06900	ELECTROCARDIOLOGY	3,296,459	29,949,920	0.110066		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,557,684	6,624,693	0.235133		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	24,648,962	43,038,948	0.572713		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	14,403,622	35,544,813	0.405224		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	16,562,159	61,221,347	0.270529		73.00
74.00	07400	RENAL DIALYSIS	1,258,669	2,183,962	0.576324		74.00
76.00	03950	ENDOSCOPY	1,520,244	10,380,687	0.146449		76.00
76.06	03330	IMAGING CENTER	2,810,433	21,774,419	0.129070		76.06
76.97	07697	CARDIAC REHABILITATION	677,973	2,598,061	0.260953		76.97
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	04950	DIABETIC CARE CENTER	0	0	0.000000		90.01
90.02	04951	ANTI-COAGULATION CLINIC	539,315	2,340,778	0.230400		90.02
90.03	04952	PALLIATIVE CARE	0	0	0.000000		90.03
90.04	04953	SPINE CENTER	430,765	386,566	1.114338		90.04
91.00	09100	EMERGENCY	17,787,613	196,922,826	0.090328		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	9,384,090	12,862,692	0.729559		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)	170,734,839	1,062,523,837			200.00
201.00		Less Observation Beds	9,384,090	0			201.00
202.00		Total (line 200 minus line 201)	161,350,749	1,062,523,837			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 15-0128 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part I Date/Time Prepared: 5/24/2024 11:48 am

Title XVIII | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	3,177,967	0	3,177,967	41,851	75.94	30.00
31.00	INTENSIVE CARE UNIT	864,755		864,755	3,196	270.57	31.00
43.00	NURSERY	109,388		109,388	2,099	52.11	43.00
200.00	Total (lines 30 through 199)	4,152,110		4,152,110	47,146		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	9,086	689,991	30.00
31.00	INTENSIVE CARE UNIT	758	205,092	31.00
43.00	NURSERY	0	0	43.00
200.00	Total (lines 30 through 199)	9,844	895,083	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-0128 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part II Date/Time Prepared: 5/24/2024 11:48 am

Title XVIII | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,674,381	156,204,355	0.017121	20,904,357	357,903	50.00
51.00	05100	RECOVERY ROOM	355,499	38,817,562	0.009158	2,811,085	25,744	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	549,481	18,856,638	0.029140	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	631,538	44,053,195	0.014336	2,433,464	34,886	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	219,543	27,435,148	0.008002	3,774,437	30,203	55.00
57.00	05700	CT SCAN	100,393	99,803,409	0.001006	7,466,869	7,512	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	228,936	19,216,261	0.011914	1,059,538	12,623	58.00
59.00	05900	CARDIAC CATHETERIZATION	787,436	127,390,768	0.006181	10,710,695	66,203	59.00
60.00	06000	LABORATORY	263,363	62,249,445	0.004231	8,966,459	37,937	60.00
64.00	06400	INTRAVENOUS THERAPY	182,684	3,232,970	0.056507	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	152,388	22,303,959	0.006832	4,548,486	31,075	65.00
66.00	06600	PHYSICAL THERAPY	591,608	12,551,986	0.047133	923,499	43,527	66.00
67.00	06700	OCCUPATIONAL THERAPY	44,969	3,782,392	0.011889	834,661	9,923	67.00
68.00	06800	SPEECH PATHOLOGY	9,491	796,037	0.011923	170,516	2,033	68.00
69.00	06900	ELECTROCARDIOLOGY	367,551	29,949,920	0.012272	2,379,124	29,197	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	218,799	6,624,693	0.033028	97,858	3,232	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,007,364	43,038,948	0.046641	5,257,187	245,200	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	172,557	35,544,813	0.004855	4,900,871	23,794	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	760,978	61,221,347	0.012430	9,030,013	112,243	73.00
74.00	07400	RENAL DIALYSIS	55,174	2,183,962	0.025263	534,543	13,504	74.00
76.00	03950	ENDOSCOPY	178,161	10,380,687	0.017163	25,361	435	76.00
76.06	03330	IMAGING CENTER	505,376	21,774,419	0.023210	16,434	381	76.06
76.97	07697	CARDIAC REHABILITATION	29,605	2,598,061	0.011395	1,116	13	76.97
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	04950	DIABETIC CARE CENTER	0	0	0.000000	0	0	90.01
90.02	04951	ANTI-COAGULATION CLINIC	7,175	2,340,778	0.003065	0	0	90.02
90.03	04952	PALLIATIVE CARE	0	0	0.000000	0	0	90.03
90.04	04953	SPINE CENTER	77,303	386,566	0.199974	0	0	90.04
91.00	09100	EMERGENCY	1,005,320	196,922,826	0.005105	11,853,847	60,514	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	506,487	12,862,692	0.039376	825,497	32,505	92.00
200.00		Total (lines 50 through 199)	12,683,560	1,062,523,837		99,525,917	1,180,587	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0128 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part III Date/Time Prepared: 5/24/2024 11:48 am

Title XVIII | Hospital | PPS

		Cost Center Description	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
			1A	1.00	2A	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
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	41,851	0.00	9,086	30.00
31.00	03100	INTENSIVE CARE UNIT		0	3,196	0.00	758	31.00
43.00	04300	NURSERY		0	2,099	0.00	0	43.00
200.00		Total (lines 30 through 199)		0	47,146		9,844	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: 15-0128 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV | Date/Time Prepared: 5/24/2024 11:48 am

Title XVIII | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
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
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
76.00	03950	ENDOSCOPY	0	0	0	0	0	76.00
76.06	03330	IMAGING CENTER	0	0	0	0	0	76.06
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
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	04950	DIABETIC CARE CENTER	0	0	0	0	0	90.01
90.02	04951	ANTI-COAGULATION CLINIC	0	0	0	0	0	90.02
90.03	04952	PALLIATIVE CARE	0	0	0	0	0	90.03
90.04	04953	SPINE CENTER	0	0	0	0	0	90.04
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0128 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV Date/Time Prepared: 5/24/2024 11:48 am

Title XVIII | Hospital | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	156,204,355	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	38,817,562	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	18,856,638	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	44,053,195	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	27,435,148	0.000000	55.00
57.00	05700	CT SCAN	0	0	0	99,803,409	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	19,216,261	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	127,390,768	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	62,249,445	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	3,232,970	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	22,303,959	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	12,551,986	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	3,782,392	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	796,037	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	29,949,920	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	6,624,693	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	43,038,948	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	35,544,813	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	61,221,347	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	2,183,962	0.000000	74.00
76.00	03950	ENDOSCOPY	0	0	0	10,380,687	0.000000	76.00
76.06	03330	IMAGING CENTER	0	0	0	21,774,419	0.000000	76.06
76.97	07697	CARDIAC REHABILITATION	0	0	0	2,598,061	0.000000	76.97
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	04950	DIABETIC CARE CENTER	0	0	0	0	0.000000	90.01
90.02	04951	ANTI-COAGULATION CLINIC	0	0	0	2,340,778	0.000000	90.02
90.03	04952	PALLIATIVE CARE	0	0	0	0	0.000000	90.03
90.04	04953	SPINE CENTER	0	0	0	386,566	0.000000	90.04
91.00	09100	EMERGENCY	0	0	0	196,922,826	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	12,862,692	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	1,062,523,837		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0128 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV | Date/Time Prepared: 5/24/2024 11:48 am

Title XVIII | Hospital | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	20,904,357	0	13,247,592	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	2,811,085	0	4,152,369	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	2,433,464	0	6,543,888	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	3,774,437	0	4,635,280	0	55.00
57.00	05700	CT SCAN	0.000000	7,466,869	0	10,376,920	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	1,059,538	0	2,539,580	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	10,710,695	0	22,862,734	0	59.00
60.00	06000	LABORATORY	0.000000	8,966,459	0	3,795,895	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	831,798	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	4,548,486	0	291,489	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	923,499	0	27,073	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	834,661	0	9,534	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	170,516	0	3,239	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	2,379,124	0	5,342,592	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	97,858	0	864,883	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	5,257,187	0	4,280,706	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	4,900,871	0	5,433,491	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	9,030,013	0	5,522,894	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	534,543	0	0	0	74.00
76.00	03950	ENDOSCOPY	0.000000	25,361	0	1,004,240	0	76.00
76.06	03330	IMAGING CENTER	0.000000	16,434	0	3,540,881	0	76.06
76.97	07697	CARDIAC REHABILITATION	0.000000	1,116	0	843,582	0	76.97
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	04950	DIABETIC CARE CENTER	0.000000	0	0	0	0	90.01
90.02	04951	ANTI-COAGULATION CLINIC	0.000000	0	0	720,297	0	90.02
90.03	04952	PALLIATIVE CARE	0.000000	0	0	0	0	90.03
90.04	04953	SPINE CENTER	0.000000	0	0	0	0	90.04
91.00	09100	EMERGENCY	0.000000	11,853,847	0	15,089,246	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	825,497	0	612,607	0	92.00
200.00		Total (lines 50 through 199)		99,525,917	0	112,572,810	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0128 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part V Date/Time Prepared: 5/24/2024 11:48 am

Title XVIII | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.096607	13,247,592	0	0	1,279,810	50.00
51.00	05100	RECOVERY ROOM	0.181013	4,152,369	0	0	751,633	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.448003	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.119877	6,543,888	0	0	784,462	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.087690	4,635,280	0	0	406,468	55.00
57.00	05700	CT SCAN	0.035691	10,376,920	0	0	370,363	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.085233	2,539,580	0	0	216,456	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.045265	22,862,734	0	0	1,034,882	59.00
60.00	06000	LABORATORY	0.196219	3,795,895	0	0	744,827	60.00
64.00	06400	INTRAVENOUS THERAPY	0.734831	831,798	0	0	611,231	64.00
65.00	06500	RESPIRATORY THERAPY	0.200345	291,489	0	0	58,398	65.00
66.00	06600	PHYSICAL THERAPY	0.420516	27,073	0	0	11,385	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.366228	9,534	0	0	3,492	67.00
68.00	06800	SPEECH PATHOLOGY	0.366668	3,239	0	0	1,188	68.00
69.00	06900	ELECTROCARDIOLOGY	0.110066	5,342,592	0	0	588,038	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.235133	864,883	0	0	203,363	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.572713	4,280,706	0	0	2,451,616	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.405224	5,433,491	0	0	2,201,781	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.270529	5,522,894	0	4,155	1,494,103	73.00
74.00	07400	RENAL DIALYSIS	0.576324	0	0	0	0	74.00
76.00	03950	ENDOSCOPY	0.146449	1,004,240	0	0	147,070	76.00
76.06	03330	IMAGING CENTER	0.129070	3,540,881	0	0	457,022	76.06
76.97	07697	CARDIAC REHABILITATION	0.260953	843,582	0	0	220,135	76.97
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	04950	DIABETIC CARE CENTER	0.000000	0	0	0	0	90.01
90.02	04951	ANTI-COAGULATION CLINIC	0.230400	720,297	0	0	165,956	90.02
90.03	04952	PALLIATIVE CARE	0.000000	0	0	0	0	90.03
90.04	04953	SPINE CENTER	1.076300	0	0	0	0	90.04
91.00	09100	EMERGENCY	0.088965	15,089,246	0	0	1,342,415	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.729559	612,607	0	0	446,933	92.00
200.00		Subtotal (see instructions)		112,572,810	0	4,155	15,993,027	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		112,572,810	0	4,155	15,993,027	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0128 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part V Date/Time Prepared: 5/24/2024 11:48 am

Title XVIII | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
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
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0		55.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	0	0		60.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
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	1,124		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.00	03950	ENDOSCOPY	0	0		76.00
76.06	03330	IMAGING CENTER	0	0		76.06
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
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	04950	DIABETIC CARE CENTER	0	0		90.01
90.02	04951	ANTI-COAGULATION CLINIC	0	0		90.02
90.03	04952	PALLIATIVE CARE	0	0		90.03
90.04	04953	SPINE CENTER	0	0		90.04
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)	0	1,124		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	1,124		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 15-0128 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part I Date/Time Prepared: 5/24/2024 11:48 am

Title XIX | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	3,177,967	0	3,177,967	41,851	75.94	30.00
31.00	INTENSIVE CARE UNIT	864,755		864,755	3,196	270.57	31.00
43.00	NURSERY	109,388		109,388	2,099	52.11	43.00
200.00	Total (lines 30 through 199)	4,152,110		4,152,110	47,146		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	1,638	124,390	30.00
31.00	INTENSIVE CARE UNIT	195	52,761	31.00
43.00	NURSERY	1,204	62,740	43.00
200.00	Total (lines 30 through 199)	3,037	239,891	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-0128 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part II Date/Time Prepared: 5/24/2024 11:48 am

Title XIX | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,674,381	156,204,355	0.017121	822,640	14,084	50.00
51.00	05100	RECOVERY ROOM	355,499	38,817,562	0.009158	261,715	2,397	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	549,481	18,856,638	0.029140	391,313	11,403	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	631,538	44,053,195	0.014336	325,950	4,673	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	219,543	27,435,148	0.008002	216,801	1,735	55.00
57.00	05700	CT SCAN	100,393	99,803,409	0.001006	1,110,160	1,117	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	228,936	19,216,261	0.011914	174,949	2,084	58.00
59.00	05900	CARDIAC CATHETERIZATION	787,436	127,390,768	0.006181	1,111,630	6,871	59.00
60.00	06000	LABORATORY	263,363	62,249,445	0.004231	1,581,058	6,689	60.00
64.00	06400	INTRAVENOUS THERAPY	182,684	3,232,970	0.056507	7,867	445	64.00
65.00	06500	RESPIRATORY THERAPY	152,388	22,303,959	0.006832	950,311	6,493	65.00
66.00	06600	PHYSICAL THERAPY	591,608	12,551,986	0.047133	83,611	3,941	66.00
67.00	06700	OCCUPATIONAL THERAPY	44,969	3,782,392	0.011889	68,340	812	67.00
68.00	06800	SPEECH PATHOLOGY	9,491	796,037	0.011923	30,305	361	68.00
69.00	06900	ELECTROCARDIOLOGY	367,551	29,949,920	0.012272	264,933	3,251	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	218,799	6,624,693	0.033028	22,766	752	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,007,364	43,038,948	0.046641	582,129	27,151	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	172,557	35,544,813	0.004855	221,880	1,077	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	760,978	61,221,347	0.012430	1,633,932	20,310	73.00
74.00	07400	RENAL DIALYSIS	55,174	2,183,962	0.025263	124,174	3,137	74.00
76.00	03950	ENDOSCOPY	178,161	10,380,687	0.017163	95,507	1,639	76.00
76.06	03330	IMAGING CENTER	505,376	21,774,419	0.023210	0	0	76.06
76.97	07697	CARDIAC REHABILITATION	29,605	2,598,061	0.011395	0	0	76.97
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	04950	DIABETIC CARE CENTER	0	0	0.000000	0	0	90.01
90.02	04951	ANTI-COAGULATION CLINIC	7,175	2,340,778	0.003065	0	0	90.02
90.03	04952	PALLIATIVE CARE	0	0	0.000000	0	0	90.03
90.04	04953	SPINE CENTER	77,303	386,566	0.199974	0	0	90.04
91.00	09100	EMERGENCY	1,005,320	196,922,826	0.005105	1,822,004	9,301	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	506,487	12,862,692	0.039376	58,644	2,309	92.00
200.00		Total (lines 50 through 199)	12,683,560	1,062,523,837		11,962,619	132,032	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0128 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part III Date/Time Prepared: 5/24/2024 11:48 am

Title XIX | Hospital | PPS

		Cost Center Description	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
			1A	1.00	2A	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
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	41,851	0.00	1,638	30.00
31.00	03100	INTENSIVE CARE UNIT		0	3,196	0.00	195	31.00
43.00	04300	NURSERY		0	2,099	0.00	1,204	43.00
200.00		Total (lines 30 through 199)		0	47,146		3,037	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: 15-0128 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV | Date/Time Prepared: 5/24/2024 11:48 am

Title XIX | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
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
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
76.00	03950	ENDOSCOPY	0	0	0	0	0	76.00
76.06	03330	IMAGING CENTER	0	0	0	0	0	76.06
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
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	04950	DIABETIC CARE CENTER	0	0	0	0	0	90.01
90.02	04951	ANTI-COAGULATION CLINIC	0	0	0	0	0	90.02
90.03	04952	PALLIATIVE CARE	0	0	0	0	0	90.03
90.04	04953	SPINE CENTER	0	0	0	0	0	90.04
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0128 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV Date/Time Prepared: 5/24/2024 11:48 am

Title XIX | Hospital | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	156,204,355	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	38,817,562	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	18,856,638	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	44,053,195	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	27,435,148	0.000000	55.00
57.00	05700	CT SCAN	0	0	0	99,803,409	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	19,216,261	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	127,390,768	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	62,249,445	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	3,232,970	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	22,303,959	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	12,551,986	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	3,782,392	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	796,037	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	29,949,920	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	6,624,693	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	43,038,948	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	35,544,813	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	61,221,347	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	2,183,962	0.000000	74.00
76.00	03950	ENDOSCOPY	0	0	0	10,380,687	0.000000	76.00
76.06	03330	IMAGING CENTER	0	0	0	21,774,419	0.000000	76.06
76.97	07697	CARDIAC REHABILITATION	0	0	0	2,598,061	0.000000	76.97
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	04950	DIABETIC CARE CENTER	0	0	0	0	0.000000	90.01
90.02	04951	ANTI-COAGULATION CLINIC	0	0	0	2,340,778	0.000000	90.02
90.03	04952	PALLIATIVE CARE	0	0	0	0	0.000000	90.03
90.04	04953	SPINE CENTER	0	0	0	386,566	0.000000	90.04
91.00	09100	EMERGENCY	0	0	0	196,922,826	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	12,862,692	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	1,062,523,837		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0128 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV Date/Time Prepared: 5/24/2024 11:48 am

Title XIX | Hospital | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	822,640	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	261,715	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	391,313	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	325,950	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	216,801	0	0	0	55.00
57.00	05700	CT SCAN	0.000000	1,110,160	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	174,949	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	1,111,630	0	0	0	59.00
60.00	06000	LABORATORY	0.000000	1,581,058	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	7,867	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	950,311	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	83,611	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	68,340	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	30,305	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	264,933	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	22,766	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	582,129	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	221,880	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	1,633,932	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	124,174	0	0	0	74.00
76.00	03950	ENDOSCOPY	0.000000	95,507	0	0	0	76.00
76.06	03330	IMAGING CENTER	0.000000	0	0	0	0	76.06
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
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	04950	DIABETIC CARE CENTER	0.000000	0	0	0	0	90.01
90.02	04951	ANTI-COAGULATION CLINIC	0.000000	0	0	0	0	90.02
90.03	04952	PALLIATIVE CARE	0.000000	0	0	0	0	90.03
90.04	04953	SPINE CENTER	0.000000	0	0	0	0	90.04
91.00	09100	EMERGENCY	0.000000	1,822,004	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	58,644	0	0	0	92.00
200.00		Total (lines 50 through 199)		11,962,619	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0128 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part V Date/Time Prepared: 5/24/2024 11:48 am

Title XIX | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.100208	0	766,116	0	0	50.00
51.00	05100	RECOVERY ROOM	0.181013	0	331,728	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.448003	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.119877	0	859,947	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.087690	0	217,436	0	0	55.00
57.00	05700	CT SCAN	0.035691	0	2,648,781	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.085233	0	259,990	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.045755	0	463,703	0	0	59.00
60.00	06000	LABORATORY	0.196219	0	1,045,762	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.734831	0	113,417	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.200345	0	88,444	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.420516	0	98,062	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.366228	0	12,136	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.366668	0	1,963	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.110066	0	188,416	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.235133	0	81,941	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.572713	0	364,286	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.405224	0	183,666	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.270529	0	257,687	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.576324	0	0	0	0	74.00
76.00	03950	ENDOSCOPY	0.146449	0	91,639	0	0	76.00
76.06	03330	IMAGING CENTER	0.129070	0	203,486	0	0	76.06
76.97	07697	CARDIAC REHABILITATION	0.260953	0	750	0	0	76.97
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	04950	DIABETIC CARE CENTER	0.000000	0	0	0	0	90.01
90.02	04951	ANTI-COAGULATION CLINIC	0.230400	0	19,302	0	0	90.02
90.03	04952	PALLIATIVE CARE	0.000000	0	0	0	0	90.03
90.04	04953	SPINE CENTER	1.114338	0	0	0	0	90.04
91.00	09100	EMERGENCY	0.090328	0	7,877,453	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.729559	0	0	0	0	92.00
200.00		Subtotal (see instructions)		0	16,176,111	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	16,176,111	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0128 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part V Date/Time Prepared: 5/24/2024 11:48 am

Title XIX | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	76,771	0		50.00
51.00	05100	RECOVERY ROOM	60,047	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	103,088	0		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	19,067	0		55.00
57.00	05700	CT SCAN	94,538	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	22,160	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	21,217	0		59.00
60.00	06000	LABORATORY	205,198	0		60.00
64.00	06400	INTRAVENOUS THERAPY	83,342	0		64.00
65.00	06500	RESPIRATORY THERAPY	17,719	0		65.00
66.00	06600	PHYSICAL THERAPY	41,237	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	4,445	0		67.00
68.00	06800	SPEECH PATHOLOGY	720	0		68.00
69.00	06900	ELECTROCARDIOLOGY	20,738	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	19,267	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	208,631	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	74,426	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	69,712	0		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.00	03950	ENDOSCOPY	13,420	0		76.00
76.06	03330	IMAGING CENTER	26,264	0		76.06
76.97	07697	CARDIAC REHABILITATION	196	0		76.97
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	04950	DIABETIC CARE CENTER	0	0		90.01
90.02	04951	ANTI-COAGULATION CLINIC	4,447	0		90.02
90.03	04952	PALLIATIVE CARE	0	0		90.03
90.04	04953	SPINE CENTER	0	0		90.04
91.00	09100	EMERGENCY	711,555	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00		Subtotal (see instructions)	1,898,205	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	1,898,205	0		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0128 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/24/2024 11:48 am

Title XVIII | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	41,851	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	41,851	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)	35,181	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)	9,086	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)	58,880,430	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)	58,880,430	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)	58,880,430	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)	1,406.91	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	12,783,184	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)	12,783,184	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0128 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/24/2024 11:48 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	9,137,990	3,196	2,859.20	758	2,167,274	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)	17,115,458	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)	32,065,916	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)	895,083	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	1,180,587	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	2,075,670	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	29,990,246	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)	6,670	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,406.91	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	9,384,090	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0128 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/24/2024 11:48 am

Title XVIII | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	3,177,967	58,880,430	0.053973	9,384,090	506,487	90.00
91.00	Nursing Program cost	0	58,880,430	0.000000	9,384,090	0	91.00
92.00	Allied health cost	0	58,880,430	0.000000	9,384,090	0	92.00
93.00	All other Medical Education	0	58,880,430	0.000000	9,384,090	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0128 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/24/2024 11:48 am

Title XIX | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	41,851	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	41,851	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)	35,181	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	1,638	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	2,099	15.00
16.00	Nursery days (title V or XIX only)	1,204	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)	60,196,404	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)	60,196,404	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)	60,196,404	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)	1,438.35	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,356,017	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	2,356,017	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0128 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/24/2024 11:48 am

Title XIX | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	1,673,570	2,099	797.32	1,204	959,973	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	9,288,702	3,196	2,906.35	195	566,738	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)	2,239,061	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)	6,121,789	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)	239,891	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	132,032	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	371,923	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	5,749,866	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)	6,670	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,438.35	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	9,593,795	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0128 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/24/2024 11:48 am

Title XIX | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	3,177,967	60,196,404	0.052793	9,593,795	506,485	90.00
91.00	Nursing Program cost	0	60,196,404	0.000000	9,593,795	0	91.00
92.00	Allied health cost	0	60,196,404	0.000000	9,593,795	0	92.00
93.00	All other Medical Education	0	60,196,404	0.000000	9,593,795	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0128 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-3 | Date/Time Prepared: 5/24/2024 11:48 am

Title XVIII | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		22,483,922		30.00
31.00	03100	INTENSIVE CARE UNIT		3,439,861		31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.096607	20,904,357	2,019,507	50.00
51.00	05100	RECOVERY ROOM	0.181013	2,811,085	508,843	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.448003	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.119877	2,433,464	291,716	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.087690	3,774,437	330,980	55.00
57.00	05700	CT SCAN	0.035691	7,466,869	266,500	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.085233	1,059,538	90,308	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.045265	10,710,695	484,820	59.00
60.00	06000	LABORATORY	0.196219	8,966,459	1,759,390	60.00
64.00	06400	INTRAVENOUS THERAPY	0.734831	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.200345	4,548,486	911,266	65.00
66.00	06600	PHYSICAL THERAPY	0.420516	923,499	388,346	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.366228	834,661	305,676	67.00
68.00	06800	SPEECH PATHOLOGY	0.366668	170,516	62,523	68.00
69.00	06900	ELECTROCARDIOLOGY	0.110066	2,379,124	261,861	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.235133	97,858	23,010	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.572713	5,257,187	3,010,859	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.405224	4,900,871	1,985,951	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.270529	9,030,013	2,442,880	73.00
74.00	07400	RENAL DIALYSIS	0.576324	534,543	308,070	74.00
76.00	03950	ENDOSCOPY	0.146449	25,361	3,714	76.00
76.06	03330	IMAGING CENTER	0.129070	16,434	2,121	76.06
76.97	07697	CARDIAC REHABILITATION	0.260953	1,116	291	76.97
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	04950	DIABETIC CARE CENTER	0.000000	0	0	90.01
90.02	04951	ANTI-COAGULATION CLINIC	0.230400	0	0	90.02
90.03	04952	PALLIATIVE CARE	0.000000	0	0	90.03
90.04	04953	SPINE CENTER	1.076300	0	0	90.04
91.00	09100	EMERGENCY	0.088965	11,853,847	1,054,577	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.729559	825,497	602,249	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		99,525,917	17,115,458	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)		99,525,917		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0128 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-3 | Date/Time Prepared: 5/24/2024 11:48 am

Title XIX | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		5,552,714		30.00
31.00	03100	INTENSIVE CARE UNIT		1,148,446		31.00
43.00	04300	NURSERY		1,235,361		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.100208	822,640	82,435	50.00
51.00	05100	RECOVERY ROOM	0.181013	261,715	47,374	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.448003	391,313	175,309	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.119877	325,950	39,074	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.087690	216,801	19,011	55.00
57.00	05700	CT SCAN	0.035691	1,110,160	39,623	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.085233	174,949	14,911	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.045755	1,111,630	50,863	59.00
60.00	06000	LABORATORY	0.196219	1,581,058	310,234	60.00
64.00	06400	INTRAVENOUS THERAPY	0.734831	7,867	5,781	64.00
65.00	06500	RESPIRATORY THERAPY	0.200345	950,311	190,390	65.00
66.00	06600	PHYSICAL THERAPY	0.420516	83,611	35,160	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.366228	68,340	25,028	67.00
68.00	06800	SPEECH PATHOLOGY	0.366668	30,305	11,112	68.00
69.00	06900	ELECTROCARDIOLOGY	0.110066	264,933	29,160	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.235133	22,766	5,353	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.572713	582,129	333,393	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.405224	221,880	89,911	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.270529	1,633,932	442,026	73.00
74.00	07400	RENAL DIALYSIS	0.576324	124,174	71,564	74.00
76.00	03950	ENDOSCOPY	0.146449	95,507	13,987	76.00
76.06	03330	IMAGING CENTER	0.129070	0	0	76.06
76.97	07697	CARDIAC REHABILITATION	0.260953	0	0	76.97
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	04950	DIABETIC CARE CENTER	0.000000	0	0	90.01
90.02	04951	ANTI-COAGULATION CLINIC	0.230400	0	0	90.02
90.03	04952	PALLIATIVE CARE	0.000000	0	0	90.03
90.04	04953	SPINE CENTER	1.114338	0	0	90.04
91.00	09100	EMERGENCY	0.090328	1,822,004	164,578	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.729559	58,644	42,784	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		11,962,619	2,239,061	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)		11,962,619		202.00

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	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)	17,236,775	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	5,450,177	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)	283,809	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)	43,970	2.04
3.00	Managed Care Simulated Payments	23,058,451	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	150.52	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 qualifing 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).	5.01	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)	5.01	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records	5.02	10.00
11.00	FTE count for residents in dental and podiatric programs.	1.45	11.00
12.00	Current year allowable FTE (see instructions)	6.46	12.00
13.00	Total allowable FTE count for the prior year.	7.60	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.	8.63	14.00
15.00	Sum of lines 12 through 14 divided by 3.	7.56	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	7.56	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).	0.050226	19.00
20.00	Prior year resident to bed ratio (see instructions)	0.049689	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)	0.049689	21.00
22.00	IME payment adjustment (see instructions)	607,466	22.00
22.01	IME payment adjustment - Managed Care (see instructions)	617,413	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)	0.01	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)	607,466	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	617,413	29.01
	Disproportionate Share Adjustment		
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	2.83	30.00
31.00	Percentage of Medicaid patient days (see instructions)	25.38	31.00
32.00	Sum of lines 30 and 31	28.21	32.00
33.00	Allowable disproportionate share percentage (see instructions)	12.49	33.00
34.00	Disproportionate share adjustment (see instructions)	708,400	34.00

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		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)	0.000249838	0.000256610	35.01
35.02	Hospital UCP, including supplemental UCP (see instructions)	1,717,489	1,523,751	35.02
35.03	Pro rata share of the hospital UCP, including supplemental UCP (see instructions)	1,284,587	383,019	35.03
36.00	Total UCP adjustment (sum of columns 1 and 2 on line 35.03)	1,667,606		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)	25,998,203		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)	26,615,616	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	1,812,041	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).	284,926	52.00
53.00	Nursing and Allied Health Managed Care payment	0	53.00
54.00	Special add-on payments for new technologies	34,473	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 intructions)	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)	28,747,056	59.00
60.00	Primary payer payments	4,461	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)	28,742,595	61.00
62.00	Deductibles billed to program beneficiaries	2,457,704	62.00
63.00	Coinsurance billed to program beneficiaries	114,000	63.00
64.00	Allowable bad debts (see instructions)	292,014	64.00
65.00	Adjusted reimbursable bad debts (see instructions)	189,809	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	26,121	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	26,360,700	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)		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)	-31,416	70.93
70.94	HRR adjustment amount (see instructions)	-139,599	70.94
70.95	Recovery of accelerated depreciation	0	70.95

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		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0	70.97
70.98	Low Volume Payment-3	0	0	70.98
70.99	HAC adjustment amount (see instructions)		0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		26,189,685	71.00
71.01	Sequestration adjustment (see instructions)		523,794	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
71.03	Sequestration adjustment-PARHM pass-throughs			71.03
72.00	Interim payments		25,254,025	72.00
72.01	Interim payments-PARHM			72.01
73.00	Tentative settlement (for contractor use only)		0	73.00
73.01	Tentative settlement-PARHM (for contractor use only)			73.01
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)		411,866	74.00
74.01	Balance due provider/program-PARHM (see instructions)			74.01
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		678,044	75.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)			
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00

		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	HSP Bonus Payment Amount			
100.00	HSP bonus amount (see instructions)	0	0	100.00
	HVBP Adjustment for HSP Bonus Payment			
101.00	HVBP adjustment factor (see instructions)	0.0000000000	0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)	0	0	102.00
	HRR Adjustment for HSP Bonus Payment			
103.00	HRR adjustment factor (see instructions)	0.0000	0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)	0	0	104.00
	Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment			
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
	Cost Reimbursement			
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)			201.00
202.00	Medicare discharges (see instructions)			202.00
203.00	Case-mix adjustment factor (see instructions)			203.00
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)			
204.00	Medicare target amount			204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)			205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)			206.00
	Adjustment to Medicare Part A Inpatient Reimbursement			
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)			208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
211.00	Total adjustment to Medicare IPPS payments (see instructions)			211.00
	Comparision 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

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		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	1,124	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	15,993,027	2.00
3.00	OPPS or REH payments	15,440,226	3.00
4.00	Outlier payment (see instructions)	39,126	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)	1,124	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	4,155	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)	4,155	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	4,155	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	3,031	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)	1,124	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)	15,479,352	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	2,698,729	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)	12,781,747	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	142,110	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)	12,923,857	30.00
31.00	Primary payer payments	3,055	31.00
32.00	Subtotal (line 30 minus line 31)	12,920,802	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)	403,954	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	262,570	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	120,374	36.00
37.00	Subtotal (see instructions)	13,183,372	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50
39.75	N95 respirator payment adjustment amount (see instructions)	0	39.75
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	13,183,372	40.00
40.01	Sequestration adjustment (see instructions)	263,667	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	12,770,705	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)	149,000	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

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

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		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		25,254,025		12,770,705	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)		25,254,025		12,770,705	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		411,866		149,000	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		25,665,891		12,919,705	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: 15-0128	Period: From 01/01/2023 To 12/31/2023	Worksheet E-1 Part II Date/Time Prepared: 5/24/2024 11:48 am
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			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: 15-0128 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E-4 | Date/Time Prepared: 5/24/2024 11:48 am

Title XVIII | Hospital | 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))			5.01	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			5.01	5.00
6.00	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)			5.02	6.00
7.00	Enter the lesser of line 5 or line 6			5.01	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.	4.35	0.67	5.02	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.	4.34	0.67	5.01	9.00
10.00	Weighted dental and podiatric resident FTE count for the current year		1.45		10.00
10.01	Unweighted dental and podiatric resident FTE count for the current year		1.45		10.01
11.00	Total weighted FTE count	4.34	2.12		11.00
12.00	Total weighted resident FTE count for the prior cost reporting year (see instructions)	5.60	2.00		12.00
13.00	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	6.45	2.18		13.00
14.00	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	5.46	2.10		14.00
15.00	Adjustment for residents in initial years of new programs	0.00	0.00		15.00
15.01	Unweighted adjustment for residents in initial years of new programs	0.00	0.00		15.01
16.00	Adjustment for residents displaced by program or hospital closure	0.00	0.00		16.00
16.01	Unweighted adjustment for residents displaced by program or hospital closure	0.00	0.00		16.01
17.00	Adjusted rolling average FTE count	5.46	2.10		17.00
18.00	Per resident amount	109,482.43	109,482.43		18.00
18.01	Per resident amount under §131 of the CAA 2021	0.00	0.00		18.01
19.00	Approved amount for resident costs	597,774	229,913	827,687	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	20.00
21.00	Direct GME FTE unweighted resident count over cap (see instructions)			0.01	21.00
22.00	Allowable additional direct GME FTE Resident Count (see instructions)			0.00	22.00
23.00	Enter the locality adjustment national average per resident amount (see instructions)			0.00	23.00
24.00	Multiply line 22 time line 23			0	24.00
25.00	Total direct GME amount (sum of lines 19 and 24)			827,687	25.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS

Provider CCN: 15-0128 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E-4 | Date/Time Prepared: 5/24/2024 11:48 am

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		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)	9,844	10,624		26.00
27.00	Total Inpatient Days (see instructions)	38,998	38,998		27.00
28.00	Ratio of inpatient days to total inpatient days	0.252423	0.272424		28.00
29.00	Program direct GME amount	208,927	225,482	434,409	29.00
29.01	Percent reduction for MA DGME		3.27		29.01
30.00	Reduction for direct GME payments for Medicare Advantage		7,373	7,373	30.00
31.00	Net Program direct GME amount			427,036	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)			2,183,962	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)			32,065,916	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)			4,461	40.00
41.00	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)			32,061,455	41.00
	Part B Reasonable Cost				
42.00	Reasonable cost (see instructions)			15,994,151	42.00
43.00	Primary payer payments (see instructions)			3,055	43.00
44.00	Total Part B reasonable cost (line 42 minus line 43)			15,991,096	44.00
45.00	Total reasonable cost (sum of lines 41 and 44)			48,052,551	45.00
46.00	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)			0.667217	46.00
47.00	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)			0.332783	47.00
	ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B				
48.00	Total program GME payment (line 31)			427,036	48.00
49.00	Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions)			284,926	49.00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)			142,110	50.00

OUTLIER RECONCILIATION AT TENTATIVE SETTLEMENT	Provider CCN: 15-0128	Period: From 01/01/2023 To 12/31/2023	Worksheet E-5 Date/Time Prepared: 5/24/2024 11:48 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: 15-0128 | Period: From 01/01/2023 To 12/31/2023 | Worksheet G | Date/Time Prepared: 5/24/2024 11:48 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	5,375	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	199,478,509	0	0	0	4.00
5.00	Other receivable	-157,935,853	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	4,105,169	0	0	0	6.00
7.00	Inventory	4,856,324	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	11,828	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)	50,521,352	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	5,442,941	0	0	0	12.00
13.00	Land improvements	3,022,362	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	200,118,080	0	0	0	15.00
16.00	Accumulated depreciation	0	0	0	0	16.00
17.00	Leasehold improvements	1,454,639	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	91,372,530	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	24,819	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	-171,287,070	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	115,656	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	130,263,957	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	692,743,703	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	692,743,703	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	873,529,012	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	1,425,697	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				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	2,260,415	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	3,686,112	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	2,988,398	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	2,988,398	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	6,674,510	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	866,854,502				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)	866,854,502	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	873,529,012	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-0128 | Period: From 01/01/2023 To 12/31/2023 | Worksheet G-1 | Date/Time Prepared: 5/24/2024 11:48 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		822,930,535		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		43,923,967				2.00
3.00	Total (sum of line 1 and line 2)		866,854,502		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)		866,854,502		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)		866,854,502		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: 15-0128 | Period: From 01/01/2023 To 12/31/2023 | Worksheet G-2 Parts I & II | Date/Time Prepared: 5/24/2024 11:48 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	127,301,972		127,301,972	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)	127,301,972		127,301,972	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	17,003,428		17,003,428	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)	17,003,428		17,003,428	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	144,305,400		144,305,400	17.00
18.00	Ancillary services	362,864,325	723,838,211	1,086,702,536	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	108,516	108,516	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	507,169,725	723,946,727	1,231,116,452	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		287,133,321		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)		287,133,321		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 15-0128 | Period: From 01/01/2023 To 12/31/2023 | Worksheet G-3 | Date/Time Prepared: 5/24/2024 11:48 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	1,231,116,452	1.00
2.00	Less contractual allowances and discounts on patients' accounts	902,863,708	2.00
3.00	Net patient revenues (line 1 minus line 2)	328,252,744	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	287,133,321	4.00
5.00	Net income from service to patients (line 3 minus line 4)	41,119,423	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	14,776	6.00
7.00	Income from investments	0	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	1,377,210	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	46,800	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	747,893	22.00
23.00	Governmental appropriations	0	23.00
24.00	MISC: ALL OTHER REVENUE	617,860	24.00
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (sum of lines 6-24)	2,804,539	25.00
26.00	Total (line 5 plus line 25)	43,923,962	26.00
27.00	INCOME TAX EXPENSE	-5	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	-5	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	43,923,967	29.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 15-0128	Period: From 01/01/2023 To 12/31/2023	Worksheet L Parts I-III Date/Time Prepared: 5/24/2024 11:48 am
	Title XVIII	Hospital	PPS

		Urban Post 10/1	Rural Pre 10/1	
		1.00	1.01	
	PART I - FULLY PROSPECTIVE METHOD			
	CAPITAL FEDERAL AMOUNT			
1.00	Capital DRG other than outlier	421,158	1,302,743	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	0	1.01
2.00	Capital DRG outlier payments	29,070		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)	108.47		3.00
4.00	Number of interns & residents (see instructions)	7.56		4.00
5.00	Indirect medical education percentage (see instructions)	1.99		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)	34,306		6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)	2.83		7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	25.38		8.00
9.00	Sum of lines 7 and 8	28.21		9.00
10.00	Allowable disproportionate share percentage (see instructions)	5.88		10.00
11.00	Disproportionate share adjustment (see instructions)	24,764		11.00
12.00	Total prospective capital payments (see instructions)	1,812,041		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