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: 15-0179	Period: From 01/01/2023 To 12/31/2023	Worksheet S Parts I-III Date/Time Prepared: 5/24/2024 12:16 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 5/24/2024 Time: 12:16 pm
2. [ ] Manually prepared cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no.

Contractor use only

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

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

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by FAIRBANKS (15-0179) 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	190,784	640	0	22,488	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	190,784	640	0	22,488	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: 15-0179	Period: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part I Date/Time Prepared: 5/24/2024 12:16 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 8102 CLEARVISTA	PO Box:			1.00
2.00	City: INDIANAPOLIS	State: IN	Zip Code: 46256	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	FAIRBANKS	150179	26900	1	01/10/2012	N	P	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									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	N	22.03
22.04	Did this hospital receive a geographic reclassification from urban to rural as a result of the revised OMB delineations for statistical areas adopted by CMS in FY 2021? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.				22.04
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	3	N		23.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0179 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I | Date/Time Prepared: 5/24/2024 12:16 pm

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	25	9	0	15	5,005	0	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00

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

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

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

		V	XVIII	XIX	
		1.00	2.00	3.00	
	Prospective Payment System (PPS)-Capital				
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y for yes or "N" for no.	N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00
	Teaching Hospitals				
56.00	Is this a hospital involved in training residents in approved GME programs? For cost reporting periods beginning prior to December 27, 2020, enter "Y" for yes or "N" for no in column 1. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.78(b)(2), see the instructions. For column 2, if the response to column 1 is "Y", or if this hospital was involved in training residents in approved GME programs in the prior year or penultimate year, and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter "Y" for yes; otherwise, enter "N" for no in column 2.	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0179 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I Date/Time Prepared: 5/24/2024 12:16 pm

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0179 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I Date/Time Prepared: 5/24/2024 12:16 pm

				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
				1.00	2.00	3.00	
	Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.						
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.99	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	1.00	0.000000	66.00
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	67.00

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

			1.00	
	Long Term Care Hospital PPS			
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.		N	80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.		N	81.00
	TEFRA Providers			
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.		N	85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.			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	Y	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)	N		106.00
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N		107.00
107.01	If this facility is a REH (line 3, column 4, is "12"), is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no. (see instructions)			107.01
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0179 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I | Date/Time Prepared: 5/24/2024 12:16 pm

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	74,458	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.	N		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		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: WISCONSON PHYSICIAN SERVICES	Contractor's Number: 08101	141.00
142.00	Street: 1500 N RITTER	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.			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: 15-0179	Period: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part I Date/Time Prepared: 5/24/2024 12:16 pm

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

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

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

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

		1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act		
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.	Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)		168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)		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: 15-0179 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part II | Date/Time Prepared: 5/24/2024 12:16 pm

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

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

		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	03/28/2024	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00

		Y/N	Legal Oper.	
		1.00	2.00	
	Approved Educational Activities			
6.00	Column 1: Are costs claimed for a nursing program? Column 2: If yes, is the provider the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing programs and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00

		Y/N	
		1.00	
	Bad Debts		
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N	13.00
14.00	If line 12 is yes, were patient deductibles and/or coinsurance amounts waived? If yes, see instructions.	N	14.00
	Bed Complement		
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.	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: 15-0179 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part II | Date/Time Prepared: 5/24/2024 12:16 pm

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

		1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)		
	Capital Related Cost		
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions		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.	Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.	N	35.00

		Y/N	Date	
		1.00	2.00	
	Home Office Costs			
36.00	Were home office costs claimed on the cost report?	Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.	Y		37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.	N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.	N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			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: 15-0179	Period: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part II Date/Time Prepared: 5/24/2024 12:16 pm

		3.00		
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	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: 15-0179 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part I | Date/Time Prepared: 5/24/2024 12:16 pm

	Component	Worksheet A Line No.	No. of Beds	Bed Days Available	CAH/REH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	52	18,980	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)		52	18,980	0.00	0	7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		52	18,980	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)		52				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: 15-0179 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part I | Date/Time Prepared: 5/24/2024 12:16 pm

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	325	25	7,409			1.00
2.00	HMO and other (see instructions)	504	5,029				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)	325	25	7,409			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)	325	25	7,409	1.00	163.50	14.00
15.00	CAH visits	0	0	0			15.00
15.10	REH hours and visits	0	0	0			15.10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				1.00	163.50	27.00
28.00	Observation Bed Days		0	0			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			66			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care	0	0	0			34.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-0179 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part I | Date/Time Prepared: 5/24/2024 12:16 pm

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	74	7	1,873	1.00
2.00	HMO and other (see instructions)			118	1,282		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	74	7	1,873	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: 15-0179 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part II | Date/Time Prepared: 5/24/2024 12:16 pm

		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	12,468,851	-56,356	12,412,495	340,083.00	36.50	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		0	0	0	0.00	0.00	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		1,506,631	0	1,506,631	17,171.00	87.74	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)		1,673,660	-7,107	1,666,553	59,793.00	27.87	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		3,296	0	3,296	31.00	106.32	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		2,362	0	2,362	21.00	112.48	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		1,649,910	0	1,649,910	31,599.00	52.21	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)		2,382,143	0	2,382,143			17.00
18.00	Wage-related costs (other) (see instructions)							18.00
19.00	Excluded areas		509,846	0	509,846			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		0	0	0			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		207,657	0	207,657			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)		445,285	0	445,285			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: 15-0179 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part II | Date/Time Prepared: 5/24/2024 12:16 pm

		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	1,291,117	-2,531	1,288,586	28,316.00	45.51	27.00
28.00	Administrative & General under contract (see inst.)		135,456	0	135,456	981.00	138.08	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	345,935	0	345,935	10,988.00	31.48	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	480,716	-3,823	476,893	20,629.00	23.12	32.00
33.00	Housekeeping under contract (see instructions)		93,282	0	93,282	1,907.00	48.92	33.00
34.00	Dietary	10.00	472,326	-118,837	353,489	15,095.00	23.42	34.00
35.00	Dietary under contract (see instructions)		146,210	0	146,210	2,080.00	70.29	35.00
36.00	Cafeteria	11.00	0	118,837	118,837	5,075.00	23.42	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	0	0	0	0.00	0.00	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	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0179 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part III Date/Time Prepared: 5/24/2024 12:16 pm

		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)		11,337,168	-56,356	11,280,812	327,880.00	34.41	1.00
2.00	Excluded area salaries (see instructions)		1,673,660	-7,107	1,666,553	59,793.00	27.87	2.00
3.00	Subtotal salaries (line 1 minus line 2)		9,663,508	-49,249	9,614,259	268,087.00	35.86	3.00
4.00	Subtotal other wages & related costs (see inst.)		1,655,568	0	1,655,568	31,651.00	52.31	4.00
5.00	Subtotal wage-related costs (see inst.)		2,827,428	0	2,827,428	0.00	29.41	5.00
6.00	Total (sum of lines 3 thru 5)		14,146,504	-49,249	14,097,255	299,738.00	47.03	6.00
7.00	Total overhead cost (see instructions)		2,965,042	-6,354	2,958,688	85,071.00	34.78	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 15-0179 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part IV | Date/Time Prepared: 5/24/2024 12:16 pm

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	432,875	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	1,266,474	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	315,873	9.00
10.00	Dental, Hearing and Vision Plan	10,845	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	5,366	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)	137,531	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	41,649	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	889,033	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	0	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	3,099,646	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: 15-0179 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part V | Date/Time Prepared: 5/24/2024 12:16 pm

	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	3,296	3,099,646	1.00
2.00	Hospital	3,296	2,589,800	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			17.00
18.00	Other	0	509,846	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 15-0179	Period: From 01/01/2023 To 12/31/2023	Worksheet S-10 Parts I & II Date/Time Prepared: 5/24/2024 12:16 pm

		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)	0.607438	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	11,338,642	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?	Y	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	23,361,885	6.00
7.00	Medicaid cost (line 1 times line 6)	14,190,897	7.00
8.00	Difference between net revenue and costs for Medicaid program (see instructions)	2,852,255	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)	2,852,255	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)	373,684	91,273	464,957	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	226,990	79,104	306,094	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)	226,990	79,104	306,094	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)	31,000	25.01
26.00	Bad debt amount (see instructions)	771,105	26.00
27.00	Medicare reimbursable bad debts (see instructions)	15,104	27.00
27.01	Medicare allowable bad debts (see instructions)	23,237	27.01
28.00	Non-Medicare bad debt amount (see instructions)	747,868	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)	462,416	29.00
30.00	Cost of uncompensated care (line 23, col. 3, plus line 29)	768,510	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	3,620,765	31.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 15-0179	Period: From 01/01/2023 To 12/31/2023	Worksheet S-10 Parts I & II Date/Time Prepared: 5/24/2024 12:16 pm

		1.00	
	PART II - HOSPITAL DATA		
	Uncompensated and Indigent Care Cost-to-Charge Ratio		
1.00	Cost to charge ratio (see instructions)	0.607438	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)	373,684	91,273	464,957	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	226,990	79,104	306,094	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)	226,990	79,104	306,094	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)	31,000	25.01
26.00	Bad debt amount (see instructions)	771,105	26.00
27.00	Medicare reimbursable bad debts (see instructions)	15,104	27.00
27.01	Medicare allowable bad debts (see instructions)	23,237	27.01
28.00	Non-Medicare bad debt amount (see instructions)	747,868	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)	462,416	29.00
30.00	Cost of uncompensated care (line 23, col. 3, plus line 29)	768,510	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	768,510	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0179 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A | Date/Time Prepared: 5/24/2024 12:16 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		0	0	845,413	845,413	1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	637	637	0	637	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,291,117	6,044,277	7,335,394	-520,165	6,815,229	5.00
7.00	00700	OPERATION OF PLANT	345,935	704,070	1,050,005	-2,268	1,047,737	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	480,716	361,895	842,611	-8,585	834,026	9.00
10.00	01000	DIETARY	472,326	696,640	1,168,966	-306,042	862,924	10.00
11.00	01100	CAFETERIA	0	0	0	290,099	290,099	11.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	918	918	0	918	16.00
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	6,638,774	1,795,142	8,433,916	-24,095	8,409,821	30.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	34,829	34,829	0	34,829	60.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	-5,995	-5,995	346	-5,649	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	130,449	130,449	-23,879	106,570	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,266,837	826,205	2,093,042	-227,152	1,865,890	90.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	299,486	109,364	408,850	0	408,850	93.99
		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)	10,795,191	10,698,431	21,493,622	23,672	21,517,294	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	70,255	70,255	0	70,255	190.00
194.00	07950	EAP	0	0	0	0	0	194.00
194.01	07951	FAIRBANKS INSTITUTE	531,556	349,800	881,356	-22,750	858,606	194.01
194.02	07952	ADULT RESIDENTIAL	1,142,104	323,296	1,465,400	-922	1,464,478	194.02
194.03	07953	MARKETING	0	0	0	0	0	194.03
194.04	07954	RECOVERY SCHOOL/(HOPE ACADEMY)	0	0	0	0	0	194.04
200.00		TOTAL (SUM OF LINES 118 through 199)	12,468,851	11,441,782	23,910,633	0	23,910,633	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0179 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A | Date/Time Prepared: 5/24/2024 12:16 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	235,412	1,080,825		1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	530,129	530,766		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-2,361,870	4,453,359		5.00
7.00	00700	OPERATION OF PLANT	75,532	1,123,269		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0		8.00
9.00	00900	HOUSEKEEPING	0	834,026		9.00
10.00	01000	DIETARY	-4,094	858,830		10.00
11.00	01100	CAFETERIA	-60,043	230,056		11.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-369	549		16.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	88,960	88,960		21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	210,298	210,298		22.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-1,569,054	6,840,767		30.00
		ANCILLARY SERVICE COST CENTERS				
54.00	05400	RADIOLOGY-DIAGNOSTIC	90	90		54.00
60.00	06000	LABORATORY	0	34,829		60.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	8,356	2,707		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	106,570		73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0		77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0		78.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	-891,059	974,831		90.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	408,850		93.99
		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)	-3,737,712	17,779,582		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	70,255		190.00
194.00	07950	EAP	0	0		194.00
194.01	07951	FAIRBANKS INSTITUTE	0	858,606		194.01
194.02	07952	ADULT RESIDENTIAL	0	1,464,478		194.02
194.03	07953	MARKETING	0	0		194.03
194.04	07954	RECOVERY SCHOOL/(HOPE ACADEMY)	0	0		194.04
200.00		TOTAL (SUM OF LINES 118 through 199)	-3,737,712	20,172,921		200.00

RECLASSIFICATIONS | Provider CCN: 15-0179 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-6 | Date/Time Prepared: 5/24/2024 12:16 pm

		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	346	1.00
	TOTALS		0	346	
	C - Drugs Charges to Pat				
1.00	DRUGS CHARGED TO PATIENTS	73.00		1,422	1.00
			0	1,422	
	D - Depreciation Expense				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	549,978	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
	TOTALS		0	549,978	
	E - Capital Insurance Costs				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	27,297	1.00
	TOTALS		0	27,297	
	F - Other Capital Rental				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	268,138	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
	TOTALS		0	268,138	
	G - STD BENEFIT				
1.00	ADMINISTRATIVE & GENERAL	5.00	0	2,531	1.00
2.00	HOUSEKEEPING	9.00	0	3,823	2.00
3.00	ADULTS & PEDIATRICS	30.00	0	34,701	3.00
4.00	CLINIC	90.00	0	7,201	4.00
5.00	PARTIAL HOSPITALIZATION PROGRAM	93.99	0	993	5.00
6.00	FAIRBANKS INSTITUTE	194.01	0	1,065	6.00
7.00	ADULT RESIDENTIAL	194.02	0	6,042	7.00
	TOTALS		0	56,356	
	I - Cafeteria				
1.00	CAFETERIA	11.00	118,837	0	1.00
2.00	CAFETERIA	11.00	0	171,262	2.00
	TOTALS		118,837	171,262	
500.00	Grand Total: Increases		118,837	1,074,799	500.00

RECLASSIFICATIONS | Provider CCN: 15-0179 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-6 | Date/Time Prepared: 5/24/2024 12:16 pm

	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	346	0		1.00
	TOTALS		0	346			
	C - Drugs Charges to Pat						
1.00	ADULTS & PEDIATRICS	30.00		1,422			1.00
			0	1,422			
	D - Depreciation Expense						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	492,868	9		1.00
2.00	OPERATION OF PLANT	7.00	0	2,268	0		2.00
3.00	HOUSEKEEPING	9.00	0	6,352	0		3.00
4.00	DIETARY	10.00	0	15,943	0		4.00
5.00	ADULTS & PEDIATRICS	30.00	0	7,694	0		5.00
6.00	CLINIC	90.00	0	1,181	0		6.00
7.00	FAIRBANKS INSTITUTE	194.01	0	22,750	0		7.00
8.00	ADULT RESIDENTIAL	194.02	0	922	0		8.00
	TOTALS		0	549,978			
	E - Capital Insurance Costs						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	27,297	12		1.00
	TOTALS		0	27,297			
	F - Other Capital Rental						
1.00	HOUSEKEEPING	9.00	0	2,233	14		1.00
2.00	ADULTS & PEDIATRICS	30.00	0	14,633	0		2.00
3.00	DRUGS CHARGED TO PATIENTS	73.00	0	25,301	0		3.00
4.00	CLINIC	90.00	0	225,971	0		4.00
	TOTALS		0	268,138			
	G - STD BENEFIT						
1.00	ADMINISTRATIVE & GENERAL	5.00	2,531	0	0		1.00
2.00	HOUSEKEEPING	9.00	3,823	0	0		2.00
3.00	ADULTS & PEDIATRICS	30.00	34,701	0	0		3.00
4.00	CLINIC	90.00	7,201	0	0		4.00
5.00	PARTIAL HOSPITALIZATION PROGRAM	93.99	993	0	0		5.00
6.00	FAIRBANKS INSTITUTE	194.01	1,065	0	0		6.00
7.00	ADULT RESIDENTIAL	194.02	6,042	0	0		7.00
	TOTALS		56,356	0			
	I - Cafeteria						
1.00	DIETARY	10.00	118,837	0	0		1.00
2.00	DIETARY	10.00	0	171,262	0		2.00
	TOTALS		118,837	171,262			
500.00	Grand Total: Decreases		175,193	1,018,443			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0179 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-7 Part I | Date/Time Prepared: 5/24/2024 12:16 pm

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	150,000	0	0	0	0	1.00
2.00	Land Improvements	0	0	0	0	0	2.00
3.00	Buildings and Fixtures	16,051,252	399,648	0	399,648	94,681	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	1,175,889	163,316	0	163,316	12,760	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	17,377,141	562,964	0	562,964	107,441	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	17,377,141	562,964	0	562,964	107,441	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	150,000	0	1.00
2.00	Land Improvements	0	0	2.00
3.00	Buildings and Fixtures	16,356,219	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	1,326,445	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	17,832,664	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	17,832,664	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0179 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-7 Part II | Date/Time Prepared: 5/24/2024 12:16 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0	0	1.00
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
3.00	Total (sum of lines 1-2)	0	0		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0179 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-7 Part III | Date/Time Prepared: 5/24/2024 12:16 pm

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	17,832,664	0	17,832,664	1.000000	0	1.00
3.00	Total (sum of lines 1-2)	17,832,664	0	17,832,664	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	785,390	0	1.00
3.00	Total (sum of lines 1-2)	0	0	0	785,390	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	27,297	0	268,138	1,080,825	1.00
3.00	Total (sum of lines 1-2)	0	27,297	0	268,138	1,080,825	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0179 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-8 | Date/Time Prepared: 5/24/2024 12:16 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	*** Cost Center Deleted ***	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)	B	-747	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	-1,077,581			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	-798,443			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-60,043	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	*** Cost Center Deleted ***	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	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	*** Cost Center Deleted ***	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	*** Cost Center Deleted ***	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0179 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-8 | Date/Time Prepared: 5/24/2024 12:16 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.00	REMOVE NEGATIVE NRCC EXPENSE	A	0	RECOVERY SCHOOL/(HOPE ACADEMY)	194.04	0	33.00
33.01	Misc Revenue	B	-1,516	ADMINISTRATIVE & GENERAL	5.00	0	33.01
33.02	Misc Revenue	B	-4,094	DIETARY	10.00	0	33.02
33.03	Misc Revenue	B	-385	MEDICAL RECORDS & LIBRARY	16.00	0	33.03
33.04	Interest Income	B	-376	ADMINISTRATIVE & GENERAL	5.00	0	33.04
33.05	Sponsorship	A	-909	ADMINISTRATIVE & GENERAL	5.00	0	33.05
33.06	APP	A	-650,383	ADULTS & PEDIATRICS	30.00	0	33.06
33.07	APP	A	-25,752	CLINIC	90.00	0	33.07
33.08	EPIC Amortization	A	174,873	CAP REL COSTS-BLDG & FIXT	1.00	9	33.08
33.09	Assisted Living Offset	A	-644,277	CLINIC	90.00	0	33.09
33.10	Sponsorship	A	0	ADMINISTRATIVE & GENERAL	5.00	0	33.10
33.11	APP	A	0	CLINIC	90.00	0	33.11
33.12	Assisted Living Offset	A	0	CLINIC	90.00	0	33.12
35.00	Bad Debt	A	-580,401	ADMINISTRATIVE & GENERAL	5.00	0	35.00
35.01	Bad Debt	A	-40,681	ADULTS & PEDIATRICS	30.00	0	35.01
35.02	Bad Debt	A	-26,997	CLINIC	90.00	0	35.02
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-3,737,712				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: 15-0179 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-8-1 | Date/Time Prepared: 5/24/2024 12:16 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	21.00	I&R SERVICES-SALARY & FRINGE	RESIDENTS	88,960	0	1.00
2.00	22.00	I&R SERVICES-OTHER PRGM. COS	RESIDENTS	210,298	0	2.00
3.00	1.00	CAP REL COSTS-BLDG & FIXT	HOME OFFICE	60,539	0	3.00
3.01	4.00	EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE	530,129	0	3.01
3.02	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE	2,780,002	4,557,923	3.02
3.03	7.00	OPERATION OF PLANT	HOME OFFICE	75,532	0	3.03
3.04	16.00	MEDICAL RECORDS & LIBRARY	HOME OFFICE	16	0	3.04
3.05	30.00	ADULTS & PEDIATRICS	HOME OFFICE	5,558	0	3.05
3.06	54.00	RADIOLOGY-DIAGNOSTIC	HOME OFFICE	90	0	3.06
4.00	71.00	MEDICAL SUPPLIES CHARGED TO	HOME OFFICE	8,356	0	4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			3,759,480	4,557,923	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:					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: 15-0179	Period: From 01/01/2023 To 12/31/2023	Worksheet A-8-1 Date/Time Prepared: 5/24/2024 12:16 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	88,960	0		1.00
2.00	210,298	0		2.00
3.00	60,539	9		3.00
3.01	530,129	0		3.01
3.02	-1,777,921	0		3.02
3.03	75,532	0		3.03
3.04	16	0		3.04
3.05	5,558	0		3.05
3.06	90	0		3.06
4.00	8,356	0		4.00
5.00	-798,443			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: 15-0179 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-8-2 | Date/Time Prepared: 5/24/2024 12:16 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	883,548	883,548	0	0	0	1.00
2.00	90.00	CLINIC	194,033	194,033	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			1,077,581	1,077,581	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	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	90.00	CLINIC	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	30.00	ADULTS & PEDIATRICS	0	0	0	883,548		1.00
2.00	90.00	CLINIC	0	0	0	194,033		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	1,077,581		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0179 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I Date/Time Prepared: 5/24/2024 12:16 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
			0	1.00	4.00	4A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	1,080,825	1,080,825				1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	530,766	24,667	555,433			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	4,453,359	179,208	57,662	4,690,229	4,690,229	5.00
7.00	00700	OPERATION OF PLANT	1,123,269	44,092	15,480	1,182,841	358,323	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	834,026	9,127	21,340	864,493	261,884	9.00
10.00	01000	DIETARY	858,830	139,152	15,818	1,013,800	307,114	10.00
11.00	01100	CAFETERIA	230,056	46,782	5,318	282,156	85,475	11.00
16.00	01600	MEDICAL RECORDS & LIBRARY	549	5,926	0	6,475	1,961	16.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	88,960	0	0	88,960	26,949	21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	210,298	0	0	210,298	63,706	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,840,767	565,792	295,517	7,702,076	2,333,217	30.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	90	0	0	90	27	54.00
60.00	06000	LABORATORY	34,829	0	0	34,829	10,551	60.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,707	0	0	2,707	820	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	106,570	0	0	106,570	32,284	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	974,831	0	56,366	1,031,197	312,385	90.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	408,850	34,524	13,357	456,731	138,359	93.99
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	17,779,582	1,049,270	480,858	17,673,452	3,933,055	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	70,255	0	0	70,255	21,283	190.00
194.00	07950	EAP	0	0	0	0	0	194.00
194.01	07951	FAIRBANKS INSTITUTE	858,606	0	23,738	882,344	267,292	194.01
194.02	07952	ADULT RESIDENTIAL	1,464,478	0	50,837	1,515,315	459,040	194.02
194.03	07953	MARKETING	0	31,555	0	31,555	9,559	194.03
194.04	07954	RECOVERY SCHOOL/(HOPE ACADEMY)	0	0	0	0	0	194.04
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)	20,172,921	1,080,825	555,433	20,172,921	4,690,229	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0179 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I Date/Time Prepared: 5/24/2024 12:16 pm

		Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	1,541,164					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0				8.00
9.00	00900	HOUSEKEEPING	16,889	0	1,143,266			9.00
10.00	01000	DIETARY	257,494	0	193,130	1,771,538		10.00
11.00	01100	CAFETERIA	86,568	0	64,929	0	519,128	11.00
16.00	01600	MEDICAL RECORDS & LIBRARY	10,966	0	8,225	0	0	16.00
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	1,046,970	0	785,270	1,771,538	394,754	30.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	97,336	90.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	63,885	0	47,916	0	27,038	93.99
		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)	1,482,772	0	1,099,470	1,771,538	519,128	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	EAP	0	0	0	0	0	194.00
194.01	07951	FAIRBANKS INSTITUTE	0	0	0	0	0	194.01
194.02	07952	ADULT RESIDENTIAL	0	0	0	0	0	194.02
194.03	07953	MARKETING	58,392	0	43,796	0	0	194.03
194.04	07954	RECOVERY SCHOOL/(HOPE ACADEMY)	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,541,164	0	1,143,266	1,771,538	519,128	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0179 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I Date/Time Prepared: 5/24/2024 12:16 pm

		Cost Center Description	MEDICAL RECORDS & LIBRARY	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES	INTERNS & RESIDENTS SERVICES-OTHER PRGM. COSTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			16.00	21.00	22.00	24.00	25.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
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
16.00	01600	MEDICAL RECORDS & LIBRARY	27,627					16.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	115,909				21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	0		274,004			22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	17,223	115,909	274,004	14,440,961	-389,913	30.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	79	0	0	196	0	54.00
60.00	06000	LABORATORY	682	0	0	46,062	0	60.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	3,527	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,446	0	0	140,300	0	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	5,879	0	0	1,446,797	0	90.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	2,318	0	0	736,247	0	93.99
		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)	27,627	115,909	274,004	16,814,090	-389,913	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	91,538	0	190.00
194.00	07950	EAP	0	0	0	0	0	194.00
194.01	07951	FAIRBANKS INSTITUTE	0	0	0	1,149,636	0	194.01
194.02	07952	ADULT RESIDENTIAL	0	0	0	1,974,355	0	194.02
194.03	07953	MARKETING	0	0	0	143,302	0	194.03
194.04	07954	RECOVERY SCHOOL/(HOPE ACADEMY)	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments		0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	27,627	115,909	274,004	20,172,921	-389,913	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0179 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I | Date/Time Prepared: 5/24/2024 12:16 pm

		Cost Center Description	Total		
			26.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
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
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD			21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD			22.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	14,051,048		30.00
		ANCILLARY SERVICE COST CENTERS			
54.00	05400	RADIOLOGY-DIAGNOSTIC	196		54.00
60.00	06000	LABORATORY	46,062		60.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,527		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	140,300		73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0		77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0		78.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	1,446,797		90.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	736,247		93.99
		OTHER REIMBURSABLE COST CENTERS			
102.00	10200	OPIOID TREATMENT PROGRAM	0		102.00
		SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	16,424,177		118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	91,538		190.00
194.00	07950	EAP	0		194.00
194.01	07951	FAIRBANKS INSTITUTE	1,149,636		194.01
194.02	07952	ADULT RESIDENTIAL	1,974,355		194.02
194.03	07953	MARKETING	143,302		194.03
194.04	07954	RECOVERY SCHOOL/(HOPE ACADEMY)	0		194.04
200.00		Cross Foot Adjustments	0		200.00
201.00		Negative Cost Centers	0		201.00
202.00		TOTAL (sum lines 118 through 201)	19,783,008		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0179 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II Date/Time Prepared: 5/24/2024 12:16 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	
			0	1.00	2A	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	24,667	24,667	24,667		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	179,208	179,208	2,560	181,768	5.00
7.00	00700	OPERATION OF PLANT	0	44,092	44,092	687	13,887	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	0	9,127	9,127	948	10,149	9.00
10.00	01000	DIETARY	0	139,152	139,152	702	11,902	10.00
11.00	01100	CAFETERIA	0	46,782	46,782	236	3,313	11.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	5,926	5,926	0	76	16.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	1,044	21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	0	0	0	0	2,469	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	565,792	565,792	13,127	90,423	30.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	1	54.00
60.00	06000	LABORATORY	0	0	0	0	409	60.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	32	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	1,251	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	2,503	12,106	90.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	34,524	34,524	593	5,362	93.99
		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	1,049,270	1,049,270	21,356	152,424	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	825	190.00
194.00	07950	EAP	0	0	0	0	0	194.00
194.01	07951	FAIRBANKS INSTITUTE	0	0	0	1,054	10,359	194.01
194.02	07952	ADULT RESIDENTIAL	0	0	0	2,257	17,790	194.02
194.03	07953	MARKETING	0	31,555	31,555	0	370	194.03
194.04	07954	RECOVERY SCHOOL/(HOPE ACADEMY)	0	0	0	0	0	194.04
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	1,080,825	1,080,825	24,667	181,768	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0179 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II | Date/Time Prepared: 5/24/2024 12:16 pm

		Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	58,666					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0				8.00
9.00	00900	HOUSEKEEPING	643	0	20,867			9.00
10.00	01000	DIETARY	9,802	0	3,525	165,083		10.00
11.00	01100	CAFETERIA	3,295	0	1,185	0	54,811	11.00
16.00	01600	MEDICAL RECORDS & LIBRARY	417	0	150	0	0	16.00
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	39,854	0	14,333	165,083	41,679	30.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	10,277	90.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	2,432	0	875	0	2,855	93.99
		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)	56,443	0	20,068	165,083	54,811	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	EAP	0	0	0	0	0	194.00
194.01	07951	FAIRBANKS INSTITUTE	0	0	0	0	0	194.01
194.02	07952	ADULT RESIDENTIAL	0	0	0	0	0	194.02
194.03	07953	MARKETING	2,223	0	799	0	0	194.03
194.04	07954	RECOVERY SCHOOL/(HOPE ACADEMY)	0	0	0	0	0	194.04
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)	58,666	0	20,867	165,083	54,811	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0179 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II Date/Time Prepared: 5/24/2024 12:16 pm

		Cost Center Description	MEDICAL RECORDS & LIBRARY	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES	INTERNS & RESIDENTS SERVICES-OTHER PRGM. COSTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			16.00	21.00	22.00	24.00	25.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
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
16.00	01600	MEDICAL RECORDS & LIBRARY	6,569					16.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	1,044				21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	0		2,469			22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,095			934,386	0	30.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	19			20	0	54.00
60.00	06000	LABORATORY	162			571	0	60.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0			32	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	344			1,595	0	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0			0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0			0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,398			26,284	0	90.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	551			47,192	0	93.99
		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)	6,569	0	0	1,010,080	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0			825	0	190.00
194.00	07950	EAP	0			0	0	194.00
194.01	07951	FAIRBANKS INSTITUTE	0			11,413	0	194.01
194.02	07952	ADULT RESIDENTIAL	0			20,047	0	194.02
194.03	07953	MARKETING	0			34,947	0	194.03
194.04	07954	RECOVERY SCHOOL/(HOPE ACADEMY)	0			0	0	194.04
200.00		Cross Foot Adjustments		1,044	2,469	3,513	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	6,569	1,044	2,469	1,080,825	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0179 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II | Date/Time Prepared: 5/24/2024 12:16 pm

		Cost Center Description	Total		
			26.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
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
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD			21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD			22.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	934,386		30.00
		ANCILLARY SERVICE COST CENTERS			
54.00	05400	RADIOLOGY-DIAGNOSTIC	20		54.00
60.00	06000	LABORATORY	571		60.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	32		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,595		73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0		77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0		78.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	26,284		90.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	47,192		93.99
		OTHER REIMBURSABLE COST CENTERS			
102.00	10200	OPIOID TREATMENT PROGRAM	0		102.00
		SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,010,080		118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	825		190.00
194.00	07950	EAP	0		194.00
194.01	07951	FAIRBANKS INSTITUTE	11,413		194.01
194.02	07952	ADULT RESIDENTIAL	20,047		194.02
194.03	07953	MARKETING	34,947		194.03
194.04	07954	RECOVERY SCHOOL/(HOPE ACADEMY)	0		194.04
200.00		Cross Foot Adjustments	3,513		200.00
201.00		Negative Cost Centers	0		201.00
202.00		TOTAL (sum lines 118 through 201)	1,080,825		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0179 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/24/2024 12:16 pm

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
			1.00	4.00	5A	5.00	7.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	93,199					1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,127	12,412,495				4.00
5.00	00500	ADMINISTRATIVE & GENERAL	15,453	1,288,586	-4,690,229	15,482,692		5.00
7.00	00700	OPERATION OF PLANT	3,802	345,935	0	1,182,841	71,817	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	787	476,893	0	864,493	787	9.00
10.00	01000	DIETARY	11,999	353,489	0	1,013,800	11,999	10.00
11.00	01100	CAFETERIA	4,034	118,837	0	282,156	4,034	11.00
16.00	01600	MEDICAL RECORDS & LIBRARY	511	0	0	6,475	511	16.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	88,960	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	0	0	0	210,298	0	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	48,788	6,604,073	0	7,702,076	48,788	30.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	90	0	54.00
60.00	06000	LABORATORY	0	0	0	34,829	0	60.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	2,707	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	106,570	0	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	1,259,636	0	1,031,197	0	90.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	2,977	298,493	0	456,731	2,977	93.99
		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)	90,478	10,745,942	-4,690,229	12,983,223	69,096	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	70,255	0	190.00
194.00	07950	EAP	0	0	0	0	0	194.00
194.01	07951	FAIRBANKS INSTITUTE	0	530,491	0	882,344	0	194.01
194.02	07952	ADULT RESIDENTIAL	0	1,136,062	0	1,515,315	0	194.02
194.03	07953	MARKETING	2,721	0	0	31,555	2,721	194.03
194.04	07954	RECOVERY SCHOOL/(HOPE ACADEMY)	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,080,825	555,433		4,690,229	1,541,164	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	11.596959	0.044748		0.302934	21.459599	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		24,667		181,768	58,666	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.001987		0.011740	0.816882	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: 15-0179 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/24/2024 12:16 pm

		Cost Center Description	LAUNDRY & LINEN SERVICE (100% ALLOCATION)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTES)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
			8.00	9.00	10.00	11.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
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	0					8.00
9.00	00900	HOUSEKEEPING	0	71,030				9.00
10.00	01000	DIETARY	0	11,999	7,409			10.00
11.00	01100	CAFETERIA	0	4,034	0	96		11.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	511	0	0	27,038,443	16.00
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	48,788	7,409	73	16,856,787	30.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	77,704	54.00
60.00	06000	LABORATORY	0	0	0	0	667,444	60.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	122	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	1,415,256	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	18	5,752,916	90.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	2,977	0	5	2,268,214	93.99
		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	68,309	7,409	96	27,038,443	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	EAP	0	0	0	0	0	194.00
194.01	07951	FAIRBANKS INSTITUTE	0	0	0	0	0	194.01
194.02	07952	ADULT RESIDENTIAL	0	0	0	0	0	194.02
194.03	07953	MARKETING	0	2,721	0	0	0	194.03
194.04	07954	RECOVERY SCHOOL/(HOPE ACADEMY)	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	0	1,143,266	1,771,538	519,128	27,627	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	16.095537	239.106222	5,407.583333	0.001022	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0	20,867	165,083	54,811	6,569	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	0.293777	22.281414	570.947917	0.000243	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: 15-0179 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/24/2024 12:16 pm

		Cost Center Description	INTERNS & RESIDENTS		
			SERVICES-SALARY & FRINGES (ASSIGNED TIME)	SERVICES-OTHER PRGM. COSTS (ASSIGNED TIME)	
			21.00	22.00	
		GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
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
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	100		21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD		100	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	100	100	30.00
		ANCILLARY SERVICE COST CENTERS			
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
60.00	06000	LABORATORY	0	0	60.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0	0	90.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	93.99
		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)	100	100	118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
194.00	07950	EAP	0	0	194.00
194.01	07951	FAIRBANKS INSTITUTE	0	0	194.01
194.02	07952	ADULT RESIDENTIAL	0	0	194.02
194.03	07953	MARKETING	0	0	194.03
194.04	07954	RECOVERY SCHOOL/(HOPE ACADEMY)	0	0	194.04
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)	115,909	274,004	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	1,159.090000	2,740.040000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	1,044	2,469	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	10.440000	24.690000	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: 15-0179 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 5/24/2024 12:16 pm

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	14,051,048		14,051,048	0	14,051,048	30.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	196		196	0	196	54.00
60.00	06000	LABORATORY	46,062		46,062	0	46,062	60.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,527		3,527	0	3,527	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	140,300		140,300	0	140,300	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0		0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0		0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,446,797		1,446,797	0	1,446,797	90.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	736,247		736,247	0	736,247	93.99
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0		0		0	102.00
200.00		Subtotal (see instructions)	16,424,177	0	16,424,177	0	16,424,177	200.00
201.00		Less Observation Beds	0		0		0	201.00
202.00		Total (see instructions)	16,424,177	0	16,424,177	0	16,424,177	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0179 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 5/24/2024 12:16 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Charges					
			Inpatient	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	16,856,787		16,856,787			30.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	77,704	0	77,704	0.002522	0.000000	54.00
60.00	06000	LABORATORY	575,507	91,937	667,444	0.069013	0.000000	60.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	122	0	122	28.909836	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,396,172	19,084	1,415,256	0.099134	0.000000	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0.000000	0.000000	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0.000000	0.000000	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	10,342	5,742,574	5,752,916	0.251489	0.000000	90.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	7,155	2,261,059	2,268,214	0.324593	0.000000	93.99
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0			102.00
200.00		Subtotal (see instructions)	18,923,789	8,114,654	27,038,443			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	18,923,789	8,114,654	27,038,443			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0179 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 5/24/2024 12:16 pm

Title XVIII | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
		ANCILLARY SERVICE COST CENTERS			
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.002522		54.00
60.00	06000	LABORATORY	0.069013		60.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	28.909836		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.099134		73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000		77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000		78.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0.251489		90.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0.324593		93.99
		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: 15-0179 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 5/24/2024 12:16 pm

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	14,440,961		14,440,961	0	14,440,961	30.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	196		196	0	196	54.00
60.00	06000	LABORATORY	46,062		46,062	0	46,062	60.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,527		3,527	0	3,527	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	140,300		140,300	0	140,300	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0		0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0		0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,446,797		1,446,797	0	1,446,797	90.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	736,247		736,247	0	736,247	93.99
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0		0		0	102.00
200.00		Subtotal (see instructions)	16,814,090	0	16,814,090	0	16,814,090	200.00
201.00		Less Observation Beds	0		0		0	201.00
202.00		Total (see instructions)	16,814,090	0	16,814,090	0	16,814,090	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0179 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 5/24/2024 12:16 pm

Title XIX | Hospital | Cost

		Cost Center Description	Charges					
			Inpatient	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	16,856,787		16,856,787			30.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	77,704	0	77,704	0.002522	0.000000	54.00
60.00	06000	LABORATORY	575,507	91,937	667,444	0.069013	0.000000	60.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	122	0	122	28.909836	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,396,172	19,084	1,415,256	0.099134	0.000000	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0.000000	0.000000	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0.000000	0.000000	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	10,342	5,742,574	5,752,916	0.251489	0.000000	90.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	7,155	2,261,059	2,268,214	0.324593	0.000000	93.99
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0			102.00
200.00		Subtotal (see instructions)	18,923,789	8,114,654	27,038,443			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	18,923,789	8,114,654	27,038,443			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0179 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 5/24/2024 12:16 pm

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
		ANCILLARY SERVICE COST CENTERS			
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000	LABORATORY	0.000000		60.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000		77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000		78.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0.000000		90.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0.000000		93.99
		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

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 15-0179 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part I Date/Time Prepared: 5/24/2024 12:16 pm

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	934,386	0	934,386	7,409	126.11	30.00
200.00	Total (lines 30 through 199)	934,386		934,386	7,409		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	325	40,986	30.00
200.00	Total (lines 30 through 199)	325	40,986	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-0179 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part II Date/Time Prepared: 5/24/2024 12:16 pm

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						
54.00	05400	RADIOLOGY-DIAGNOSTIC	20	77,704	0.000257	4,446	1	54.00
60.00	06000	LABORATORY	571	667,444	0.000856	23,764	20	60.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	32	122	0.262295	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,595	1,415,256	0.001127	64,695	73	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0.000000	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0.000000	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	26,284	5,752,916	0.004569	1,060	5	90.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	47,192	2,268,214	0.020806	6,913	144	93.99
200.00		Total (lines 50 through 199)	75,694	10,181,656		100,878	243	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0179 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part III Date/Time Prepared: 5/24/2024 12:16 pm

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
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	7,409	0.00	325	30.00
200.00		Total (lines 30 through 199)		0	7,409		325	200.00

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

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0179 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV | Date/Time Prepared: 5/24/2024 12:16 pm

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						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
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: 15-0179 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV | Date/Time Prepared: 5/24/2024 12:16 pm

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						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	77,704	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	667,444	0.000000	60.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	122	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,415,256	0.000000	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0.000000	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0.000000	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	5,752,916	0.000000	90.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	2,268,214	0.000000	93.99
200.00		Total (lines 50 through 199)	0	0	0	10,181,656		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0179 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV | Date/Time Prepared: 5/24/2024 12:16 pm

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						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	4,446	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	23,764	0	384	0	60.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	64,695	0	0	0	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	1,060	0	118,634	0	90.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0.000000	6,913	0	67,911	0	93.99
200.00		Total (lines 50 through 199)		100,878	0	186,929	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0179 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part V Date/Time Prepared: 5/24/2024 12:16 pm

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						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.002522	0	0	0	0	54.00
60.00	06000	LABORATORY	0.069013	384	0	0	27	60.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	28.909836	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.099134	0	0	241	0	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.251489	118,634	0	0	29,835	90.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0.324593	67,911	0	0	22,043	93.99
200.00		Subtotal (see instructions)		186,929	0	241	51,905	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		186,929	0	241	51,905	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0179 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part V Date/Time Prepared: 5/24/2024 12:16 pm

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				
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	06000	LABORATORY	0	0		60.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	24		73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0		77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0		78.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0		93.99
200.00		Subtotal (see instructions)	0	24		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	24		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0179 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part V Date/Time Prepared: 5/24/2024 12:16 pm

Title XIX | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.002522	0	0	0	0	54.00
60.00	06000	LABORATORY	0.069013	0	0	0	0	60.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	28.909836	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.099134	0	15	0	0	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.251489	0	43,397	0	0	90.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0.324593	0	13,454	0	0	93.99
200.00		Subtotal (see instructions)		0	56,866	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	56,866	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0179 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part V Date/Time Prepared: 5/24/2024 12:16 pm

Title XIX | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
		ANCILLARY SERVICE COST CENTERS			
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
60.00	06000	LABORATORY	0	0	60.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1	0	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	10,914	0	90.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	4,367	0	93.99
200.00		Subtotal (see instructions)	15,282	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	15,282	0	202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0179 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/24/2024 12:16 pm

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)	7,409	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	7,409	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)	7,409	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)	325	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)	14,051,048	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)	14,051,048	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)	14,051,048	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)	1,896.48	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	616,356	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)	616,356	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0179 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/24/2024 12:16 pm

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)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	10,575	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)	626,931	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)	40,986	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	243	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	41,229	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	585,702	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
55.01	Permanent adjustment amount per discharge	0.00	55.01
55.02	Adjustment amount per discharge (contractor use only)	0.00	55.02
56.00	Target amount (line 54 x sum of lines 55, 55.01, and 55.02)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)	0.00	59.00
60.00	Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)	0.00	60.00
61.00	Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0179 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/24/2024 12:16 pm

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	934,386	14,051,048	0.066499	0	0	90.00
91.00	Nursing Program cost	0	14,051,048	0.000000	0	0	91.00
92.00	Allied health cost	0	14,051,048	0.000000	0	0	92.00
93.00	All other Medical Education	0	14,051,048	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0179	Period: From 01/01/2023 To 12/31/2023	Worksheet D-1 Date/Time Prepared: 5/24/2024 12:16 pm
	Title XIX	Hospital	Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	7,409	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	7,409	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)	7,409	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)	25	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)	14,440,961	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)	14,440,961	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)	14,440,961	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)	1,949.11	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	48,728	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	48,728	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0179 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/24/2024 12:16 pm

Title XIX | Hospital | Cost

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	663	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)	49,391	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
55.01	Permanent adjustment amount per discharge	0.00	55.01
55.02	Adjustment amount per discharge (contractor use only)	0.00	55.02
56.00	Target amount (line 54 x sum of lines 55, 55.01, and 55.02)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)	0.00	59.00
60.00	Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)	0.00	60.00
61.00	Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0179 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/24/2024 12:16 pm

Title XIX | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	934,386	14,440,961	0.064704	0	0	90.00
91.00	Nursing Program cost	0	14,440,961	0.000000	0	0	91.00
92.00	Allied health cost	0	14,440,961	0.000000	0	0	92.00
93.00	All other Medical Education	0	14,440,961	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0179 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-3 | Date/Time Prepared: 5/24/2024 12:16 pm

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		733,635		30.00
		ANCILLARY SERVICE COST CENTERS				
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.002522	4,446	11	54.00
60.00	06000	LABORATORY	0.069013	23,764	1,640	60.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	28.909836	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.099134	64,695	6,413	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.251489	1,060	267	90.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0.324593	6,913	2,244	93.99
200.00		Total (sum of lines 50 through 94 and 96 through 98)		100,878	10,575	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)		100,878		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0179 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-3 | Date/Time Prepared: 5/24/2024 12:16 pm

Title XIX | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		63,323		30.00
		ANCILLARY SERVICE COST CENTERS				
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.002522	0	0	54.00
60.00	06000	LABORATORY	0.069013	2,503	173	60.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	28.909836	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.099134	4,548	451	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.251489	155	39	90.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0.324593	0	0	93.99
200.00		Total (sum of lines 50 through 94 and 96 through 98)		7,206	663	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)		7,206		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0179	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part A Date/Time Prepared: 5/24/2024 12:16 pm
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		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)	503,809	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	71,853	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)	0	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)	0	2.04
3.00	Managed Care Simulated Payments	961,175	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	52.00	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).	1.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.	0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)	0.00	8.02
8.21	The amount of increase if the hospital was awarded FTE cap slots under §126 of the CAA 2021 (see instructions)	0.00	8.21
9.00	Sum of lines 5 and 5.01, plus line 6, plus lines 6.26 through 6.49, minus lines 7 and 7.01, plus or minus line 7.02, plus/minus line 8, plus lines 8.01 through 8.27 (see instructions)	1.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records	1.00	10.00
11.00	FTE count for residents in dental and podiatric programs.	0.00	11.00
12.00	Current year allowable FTE (see instructions)	1.00	12.00
13.00	Total allowable FTE count for the prior year.	0.99	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.	0.92	14.00
15.00	Sum of lines 12 through 14 divided by 3.	0.97	15.00
16.00	Adjustment for residents in initial years of the program (see instructions)	0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure	0.00	17.00
18.00	Adjusted rolling average FTE count	0.97	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).	0.018654	19.00
20.00	Prior year resident to bed ratio (see instructions)	0.019038	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)	0.018654	21.00
22.00	IME payment adjustment (see instructions)	5,839	22.00
22.01	IME payment adjustment - Managed Care (see instructions)	9,749	22.01
	Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA		
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).	0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)	0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)	0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)	0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)	0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)	0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)	0	28.01
29.00	Total IME payment (sum of lines 22 and 28)	5,839	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	9,749	29.01
	Disproportionate Share Adjustment		
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	13.24	30.00
31.00	Percentage of Medicaid patient days (see instructions)	67.61	31.00
32.00	Sum of lines 30 and 31	80.85	32.00
33.00	Allowable disproportionate share percentage (see instructions)	12.00	33.00
34.00	Disproportionate share adjustment (see instructions)	17,270	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)	0.000045683	0.000039861	35.01
35.02	Hospital UCP, including supplemental UCP (see instructions)	314,046	236,697	35.02
35.03	Pro rata share of the hospital UCP, including supplemental UCP (see instructions)	234,889	59,498	35.03
36.00	Total UCP adjustment (sum of columns 1 and 2 on line 35.03)	294,387		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)	893,158		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)	902,907	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	44,678	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)	0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).	0	52.00
53.00	Nursing and Allied Health Managed Care payment	0	53.00
54.00	Special add-on payments for new technologies	0	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)	947,585	59.00
60.00	Primary payer payments	13,449	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)	934,136	61.00
62.00	Deductibles billed to program beneficiaries	86,344	62.00
63.00	Coinsurance billed to program beneficiaries	4,000	63.00
64.00	Allowable bad debts (see instructions)	22,192	64.00
65.00	Adjusted reimbursable bad debts (see instructions)	14,425	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	22,192	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	858,217	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)	0	70.93
70.94	HRR adjustment amount (see instructions)	0	70.94
70.95	Recovery of accelerated depreciation	0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0179	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part A Date/Time Prepared: 5/24/2024 12:16 pm
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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)		858,217	71.00
71.01	Sequestration adjustment (see instructions)		17,164	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		650,269	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)		190,784	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		174,190	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)	24	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	51,905	2.00
3.00	OPPS or REH payments	50,584	3.00
4.00	Outlier payment (see instructions)	0	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs 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)	24	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	241	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)	241	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)	241	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	217	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)	24	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)	50,584	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)	11,215	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)	39,393	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
28.50	REH facility payment amount (see instructions)		28.50
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27, 28, 28.50 and 29)	39,393	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	39,393	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)	1,045	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	679	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	1,045	36.00
37.00	Subtotal (see instructions)	40,072	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)	40,072	40.00
40.01	Sequestration adjustment (see instructions)	801	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	38,631	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)	640	43.00
43.01	Balance due provider/program-PARHM (see instructions)		43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0179	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part B Date/Time Prepared: 5/24/2024 12:16 pm
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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 | Provider CCN: 15-0179 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E-1 Part I | Date/Time Prepared: 5/24/2024 12:16 pm

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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		650,269		38,631	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)		650,269		38,631	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		190,784		640	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		841,053		39,271	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: 15-0179	Period: From 01/01/2023 To 12/31/2023	Worksheet E-1 Part II Date/Time Prepared: 5/24/2024 12:16 pm
	Title XVIII	Hospital	PPS

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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0179	Period: From 01/01/2023 To 12/31/2023	Worksheet E-3 Part VII Date/Time Prepared: 5/24/2024 12:16 pm
	Title XIX	Hospital	Cost

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	49,391		1.00
2.00	Medical and other services		15,282	2.00
3.00	Organ acquisition (certified transplant programs only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	49,391	15,282	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	49,391	15,282	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	0		8.00
9.00	Ancillary service charges	7,206	56,866	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	7,206	56,866	12.00
	CUSTOMARY CHARGES			
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	7,206	56,866	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	0	41,584	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	42,185	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	7,206	15,282	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	7,206	15,282	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	42,185	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	7,206	15,282	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	7,206	15,282	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	7,206	15,282	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	7,206	15,282	40.00
41.00	Interim payments	0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	7,206	15,282	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

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

Provider CCN: 15-0179 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E-4 | Date/Time Prepared: 5/24/2024 12:16 pm

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))			1.00	4.00
4.01	ACA Section 5503 increase to the Direct GME FTE Cap (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.01
4.02	ACA Section 5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.02
4.21	The amount of increase if the hospital was awarded FTE cap slots under §126 of the CAA 2021 (see instructions)			0.00	4.21
5.00	FTE adjusted cap (line 1 plus and 1.01, plus line 2, plus lines 2.26 through 2.49, minus lines 3 and 3.01, plus or minus line 3.02, plus or minus line 4, plus lines 4.01 through 4.27			1.00	5.00
6.00	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)			1.00	6.00
7.00	Enter the lesser of line 5 or line 6			1.00	7.00
		Primary Care	Other	Total	
		1.00	2.00	3.00	
8.00	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year.	0.00	1.00	1.00	8.00
9.00	If line 6 is less than 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount on line 6. For cost reporting periods beginning on or after October 1, 2022, or if Worksheet S-2, Part I, line 68, is "Y", see instructions.	0.00	1.00	1.00	9.00
10.00	Weighted dental and podiatric resident FTE count for the current year		0.00		10.00
10.01	Unweighted dental and podiatric resident FTE count for the current year		0.00		10.01
11.00	Total weighted FTE count	0.00	1.00		11.00
12.00	Total weighted resident FTE count for the prior cost reporting year (see instructions)	0.00	0.99		12.00
13.00	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	0.00	0.92		13.00
14.00	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	0.00	0.97		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	0.00	0.97		17.00
18.00	Per resident amount	0.00	0.00		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	0	0	0	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)			0.00	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)			0	25.00

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

Provider CCN: 15-0179 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E-4 | Date/Time Prepared: 5/24/2024 12:16 pm

Title XVIII | Hospital | PPS

		Inpatient Part A	Managed Care	Total	
		1.00	2.00	3.00	
	COMPUTATION OF PROGRAM PATIENT LOAD				
26.00	Inpatient Days (see instructions) (Title XIX - see S-2 Part IX, line 3.02, column 2)	325	504		26.00
27.00	Total Inpatient Days (see instructions)	7,409	7,409		27.00
28.00	Ratio of inpatient days to total inpatient days	0.043866	0.068025		28.00
29.00	Program direct GME amount	0	0	0	29.00
29.01	Percent reduction for MA DGME		3.27		29.01
30.00	Reduction for direct GME payments for Medicare Advantage		0	0	30.00
31.00	Net Program direct GME amount			0	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)			0	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)			626,931	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)			13,449	40.00
41.00	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)			613,482	41.00
	Part B Reasonable Cost				
42.00	Reasonable cost (see instructions)			51,929	42.00
43.00	Primary payer payments (see instructions)			0	43.00
44.00	Total Part B reasonable cost (line 42 minus line 43)			51,929	44.00
45.00	Total reasonable cost (sum of lines 41 and 44)			665,411	45.00
46.00	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)			0.921960	46.00
47.00	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)			0.078040	47.00
	ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B				
48.00	Total program GME payment (line 31)			0	48.00
49.00	Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions)			0	49.00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)			0	50.00

OUTLIER RECONCILIATION AT TENTATIVE SETTLEMENT	Provider CCN: 15-0179	Period: From 01/01/2023 To 12/31/2023	Worksheet E-5 Date/Time Prepared: 5/24/2024 12:16 pm
	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: 15-0179 | Period: From 01/01/2023 To 12/31/2023 | Worksheet G | Date/Time Prepared: 5/24/2024 12:16 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	1,053	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	10,000	0	0	0	3.00
4.00	Accounts receivable	7,091,547	0	0	0	4.00
5.00	Other receivable	-3,524,487	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	135,803	0	0	0	6.00
7.00	Inventory	15,278	0	0	0	7.00
8.00	Prepaid expenses	10,065	0	0	0	8.00
9.00	Other current assets	286	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)	3,739,545	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	150,000	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	16,356,218	0	0	0	15.00
16.00	Accumulated depreciation	0	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	1,189,482	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	76,963	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	-2,372,294	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	60,000	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	15,460,369	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	2,758,036	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	2,758,036	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	21,957,950	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	9,042	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	107,372	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	116,414	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	41,558	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	41,558	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	157,972	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	21,799,978				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)	21,799,978	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	21,957,950	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-0179 | Period: From 01/01/2023 To 12/31/2023 | Worksheet G-1 | Date/Time Prepared: 5/24/2024 12:16 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		21,842,590		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-42,612				2.00
3.00	Total (sum of line 1 and line 2)		21,799,978		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)		21,799,978		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)		21,799,978		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: 15-0179 | Period: From 01/01/2023 To 12/31/2023 | Worksheet G-2 Parts I & II | Date/Time Prepared: 5/24/2024 12:16 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	16,837,094		16,837,094	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)	16,837,094		16,837,094	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	16,837,094		16,837,094	17.00
18.00	Ancillary services	12,463,636	11,220,845	23,684,481	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	29,300,730	11,220,845	40,521,575	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		23,910,633		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)		23,910,633		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 15-0179 | Period: From 01/01/2023 To 12/31/2023 | Worksheet G-3 | Date/Time Prepared: 5/24/2024 12:16 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	40,521,575	1.00
2.00	Less contractual allowances and discounts on patients' accounts	17,625,090	2.00
3.00	Net patient revenues (line 1 minus line 2)	22,896,485	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	23,910,633	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-1,014,148	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	819,487	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	84,372	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	385	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	58,448	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	MISC: ALL OTHER REVENUE	8,846	24.00
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (sum of lines 6-24)	971,538	25.00
26.00	Total (line 5 plus line 25)	-42,610	26.00
27.00	ROUNDING	2	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	2	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-42,612	29.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 15-0179	Period: From 01/01/2023 To 12/31/2023	Worksheet L Parts I-III Date/Time Prepared: 5/24/2024 12:16 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	44,083	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	0	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)	20.48	3.00
4.00	Number of interns & residents (see instructions)	0.97	4.00
5.00	Indirect medical education percentage (see instructions)	1.35	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)	595	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)	0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	0.00	8.00
9.00	Sum of lines 7 and 8	0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)	0.00	10.00
11.00	Disproportionate share adjustment (see instructions)	0	11.00
12.00	Total prospective capital payments (see instructions)	44,678	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