

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: 15-0090	Period: From 01/01/2023 To 12/31/2023	Worksheet S Parts I-III Date/Time Prepared: 5/30/2024 3:45 pm
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**PART I - COST REPORT STATUS**

Provider use only	1. <input checked="" type="checkbox"/> Electronically prepared cost report 2. <input type="checkbox"/> Manually prepared cost report	Date: 5/30/2024	Time: 3:45 pm
	3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report 4. <input checked="" type="checkbox"/> Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no.		
Contractor use only	5. <input checked="" type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. <input checked="" type="checkbox"/> Initial Report for this Provider CCN 9. <input checked="" type="checkbox"/> Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. <input type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.

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

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by FRANCISCAN HEALTH- DYER ( 15-0090 ) 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			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			2
3	Signatory Title			3
4	Date			4

	Title V	Title XVIII		HIT	Title XIX	
		Part A	Part B			
	1.00	2.00	3.00	4.00	5.00	
<b>PART III - SETTLEMENT SUMMARY</b>						
1.00	HOSPITAL	0	587,037	51,668	0	1.00
2.00	SUBPROVIDER - IPF	0	0	0	0	2.00
3.00	SUBPROVIDER - IRF	0	-96,351	5	0	3.00
4.00	SUBPROVIDER (OTHER)					4.00
5.00	SWING BED - SNF	0	0	0	0	5.00
6.00	SWING BED - NF	0			0	6.00
9.00	HOME HEALTH AGENCY I	0	0	0	0	9.00
200.00	TOTAL	0	490,686	51,673	0	200.00

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-0090	Period: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part I Date/Time Prepared: 5/30/2024 3:45 pm
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1.00 Hospital and Hospital Health Care Complex Address:		2.00 PO Box:		3.00 State: IN		4.00 Zip Code: 46311-1799		County: LAKE		1.00
1.00	Street: 24 JOLIET STREET	2.00		3.00		4.00		5.00		2.00
2.00	City: DYER	3.00		4.00		5.00		6.00		7.00

	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	FRANCISCAN HEALTH- DYER	150090	23844	1	07/01/1966	N	P	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF	FRANCISCAN HEALTH - DYER -REHAB	15T090	23844	5	01/01/2002	N	P	T	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	ST. MARGARET HOME CARE	157145	23844		01/01/2023	N	P	N	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)					1		21.00		
						1.00	2.00	3.00		

Inpatient PPS Information										
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.				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: 15-0090		Period: From 01/01/2023 To 12/31/2023		Worksheet S-2 Part I Date/Time Prepared: 5/30/2024 3:45 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.	88	71	1,597	454	5,823	105	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.	7	0	0	9	108		25.00	
						Urban/Rural Status	Date of Geographic		
						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.					1		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.					01/01/2023	12/31/2023	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)					Y	N	40.00	
						V	XVIII	XIX	
						1.00	2.00	3.00	
<b>Prospective Payment System (PPS)-Capital</b>									
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)					N	Y	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.					N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.					N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					N	N	N	48.00
<b>Teaching Hospitals</b>									
56.00	Is this a hospital involved in training residents in approved GME programs? For cost reporting periods beginning prior to December 27, 2020, enter "Y" for yes or "N" for no in column 1. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.78(b)(2), see the instructions. For column 2, if the response to column 1 is "Y", or if this hospital was involved in training residents in approved GME programs in the prior year or penultimate year, and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter "Y" for yes; otherwise, enter "N" for no in column 2.					Y	Y		56.00
57.00	For cost reporting periods beginning prior to December 27, 2020, if line 56, column 1, is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.77(e)(1)(iv) and (v), regardless of which month(s) of the cost report the residents were on duty, if the response to line 56 is "Y" for yes, enter "Y" for yes in column 1, do not complete column 2, and complete Worksheet E-4.					Y			57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.					N			58.00

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		V	XVIII	XIX			
		1.00	2.00	3.00			
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N					59.00
		NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code			
		1.00	2.00	3.00			
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2.	Y	Y				60.00
60.01	If line 60 is yes, complete columns 2 and 3 for each program. (see instructions)		23.00	1			60.01
60.02	If line 60 is yes, complete columns 2 and 3 for each program. (see instructions)		23.01	1			60.02
60.03	If line 60 is yes, complete columns 2 and 3 for each program. (see instructions)		23.02	1			60.03
		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	
62.00	ACA Provisions Affecting the Health Resources and Services Administration (HRSA) Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)					0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)					0.00	62.01
	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

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			Unweighted FTEs Nonprovi der Site	Unweighted FTEs in Hospi tal	Ratio (col. 1/ (col. 1 + col. 2))		
			1.00	2.00	3.00		
64.00	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. 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	5.75	0.000000		64.00
			Program Name	Program Code	Unweighted FTEs Nonprovi der Site	Unweighted FTEs in Hospi tal	Ratio (col. 3/ (col. 3 + col. 4))
			1.00	2.00	3.00	4.00	5.00
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000		65.00
			Unweighted FTEs Nonprovi der Site	Unweighted FTEs in Hospi tal	Ratio (col. 1/ (col. 1 + col. 2))		
			1.00	2.00	3.00		
66.00	Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010 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	5.74	0.000000		66.00
			Program Name	Program Code	Unweighted FTEs Nonprovi der Site	Unweighted FTEs in Hospi tal	Ratio (col. 3/ (col. 3 + col. 4))
			1.00	2.00	3.00	4.00	5.00
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000		67.00

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			1.00				
68.00	Direct GME in Accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-49072 (August 10, 2022) For a cost reporting period beginning prior to October 1, 2022, did you obtain permission from your MAC to apply the new DGME formula in accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-49072 (August 10, 2022)?					68.00	
			1.00	2.00	3.00		
<b>Inpatient Psychiatric Facility PPS</b>							
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.			N		70.00	
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)				0	71.00	
<b>Inpatient Rehabilitation Facility PPS</b>							
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.			Y		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				
<b>Long Term Care Hospital PPS</b>							
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	
<b>TEFRA Providers</b>							
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			
<b>Title V and XIX Services</b>							
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	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-0090		Period: From 01/01/2023 To 12/31/2023		Worksheet S-2 Part I Date/Time Prepared: 5/30/2024 3:45 pm	
		V	XIX				
		1.00	2.00				
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y			98.00	
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y			98.01	
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y			98.02	
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N			98.03	
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N			98.04	
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y			98.05	
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y			98.06	
<b>Rural Providers</b>							
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	
<b>Miscellaneous Cost Reporting Information</b>							
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			115.00	
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.		N			116.00	
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.		Y			117.00	
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.			2	118.00		

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-0090	Period: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part I Date/Time Prepared: 5/30/2024 3:45 pm
		Premiums	Losses	Insurance
		1.00	2.00	3.00
118.01	List amounts of malpractice premiums and paid losses:	643,060	0	247,821
		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	
119.00	DO NOT USE THIS LINE			
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
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.		Y	
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.		Y	5.04
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	
<b>Certified Transplant Center Information</b>				
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	
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.			
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.			
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.			
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.			
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.			
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.			
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.			
133.00	Removed and reserved			
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.			
<b>All Providers</b>				
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	158014
		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: FRANCISCAN ALLIANCE, INC	Contractor's Name: WISCONSIN PHYSICIAN SERVICES	Contractor's Number: 08101	141.00
142.00	Street: 1515 DRAGOON TRAIL	PO Box: -		142.00
143.00	City: MI SHAWAKA	State: IN	Zip Code: 46546	143.00
		1.00	2.00	
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: 15-0090		Period: From 01/01/2023 To 12/31/2023		Worksheet S-2 Part I Date/Time Prepared: 5/30/2024 3:45 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	N	155.00	
156.00	Subprovider - IPF	N	N	N	N	N	156.00	
157.00	Subprovider - IRF	N	N	N	N	N	157.00	
158.00	SUBPROVIDER						158.00	
159.00	SNF	N	N	N	N	N	159.00	
160.00	HOME HEALTH AGENCY	N	N	N	N	N	160.00	
161.00	CMHC		N	N	N	N	161.00	
1.00								
Multi campus								
165.00	Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.						N	165.00
		Name	County	State	Zip Code	CBSA	FTE/Campus	
		0	1.00	2.00	3.00	4.00	5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00	166.00
1.00								
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act								
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.						Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)							168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)							168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)						0.00	169.00
		Beginning	Ending					
		1.00	2.00					
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)							170.00
		1.00	2.00					
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)						N	0171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 15-0090		Period: From 01/01/2023 To 12/31/2023		Worksheet S-2 Part II Date/Time Prepared: 5/30/2024 3:45 pm	
				Y/N	Date		
				1.00	2.00		
<b>PART II - HOSPITAL AND HOSPITAL HEALTHCARE COMPLEX REIMBURSEMENT QUESTIONNAIRE</b>							
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.							
<b>COMPLETED BY ALL HOSPITALS</b>							
<b>Provider Organization and Operation</b>							
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N					1.00
				Y/N	Date	V/I	
				1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N					2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N					3.00
				Y/N	Type	Date	
				1.00	2.00	3.00	
<b>Financial Data and Reports</b>							
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	04/17/2024			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		
<b>Approved Educational Activities</b>							
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			
<b>Bad Debts</b>							
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
<b>Bed Complement</b>							
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.				Y		15.00
				Part A		Part B	
				Y/N	Date	Y/N	Date
				1.00	2.00	3.00	4.00
<b>PS&amp;R Data</b>							
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	04/09/2024		Y	04/09/2024	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: 15-0090	Period: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part II Date/Time Prepared: 5/30/2024 3:45 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		21.00
				1.00	
<b>COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)</b>					
<b>Capital Related Cost</b>					
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions			N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.			N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions			N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.			N	25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.			N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.			N	27.00
<b>Interest Expense</b>					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.			N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions			N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.			N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.			N	31.00
<b>Purchased Services</b>					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.			N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				33.00
<b>Provider-Based Physicians</b>					
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	
<b>Home Office Costs</b>					
36.00	Were home office costs claimed on the cost report?			Y	36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			Y	37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			N	38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			N	39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			N	40.00
				1.00	2.00
<b>Cost Report Preparer Contact Information</b>					
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.	HALL		JAMES	41.00
42.00	Enter the employer/company name of the cost report preparer	FRANCSAN ALLIANCE INC			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	(614) 565-2739		JAMES.HALL@FRANCSANALLIANCE.ORG	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 15-0090	Period: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part II Date/Time Prepared: 5/30/2024 3:45 pm
		3.00		
<b>Cost Report Preparer Contact Information</b>				
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.	REIMBURSEMENT ANALYST		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: 15-0090

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
5/30/2024 3:45 pm

Component	Worksheet A	No. of Beds	Bed Days Available	CAH/REH Hours	I/P Days / O/P		
	Line No.				Visits	Trips	
	1.00	2.00	3.00	4.00	5.00		
<b>PART I - STATISTICAL DATA</b>							
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	145	52,925	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)		145	52,925	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	14	5,110	0.00	0	8.00
9.00	CORONARY CARE UNIT	32.00	0	0	0.00	0	9.00
10.00	BURN INTENSIVE CARE UNIT	33.00	0	0	0.00	0	10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	NEONATAL INTENSIVE CARE UNIT	35.00	7	2,555	0.00	0	12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		166	60,590	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	41.00	15	5,475		0	17.00
18.00	SUBPROVIDER	42.00	0	0		0	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	101.00				0	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)		181				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: 15-0090

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
5/30/2024 3:45 pm

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVII I	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
	6.00	7.00	8.00	9.00	10.00	
<b>PART I - STATISTICAL DATA</b>						
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)	7,090	303	24,760		1.00
2.00	HMO and other (see instructions)	5,303	5,823			2.00
3.00	HMO IPF Subprovider	0	0			3.00
4.00	HMO IRF Subprovider	695	108			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	0		6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	7,090	303	24,760		7.00
8.00	INTENSIVE CARE UNIT	837	1,044	2,392		8.00
9.00	CORONARY CARE UNIT	0	0	0		9.00
10.00	BURN INTENSIVE CARE UNIT	0	0	0		10.00
11.00	SURGICAL INTENSIVE CARE UNIT					11.00
12.00	NEONATAL INTENSIVE CARE UNIT	0	305	350		12.00
13.00	NURSERY		558	704		13.00
14.00	Total (see instructions)	7,927	2,210	28,206	5.74	836.98
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	2,694	16	3,964	0.00	0.00
18.00	SUBPROVIDER		0	0	0.00	0.00
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	23,826	0	56,477	0.00	0.00
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
27.00	Total (sum of lines 14-26)				5.74	836.98
28.00	Observation Bed Days		686	2,797		28.00
29.00	Ambulance Trips	0				29.00
30.00	Employee discount days (see instruction)			0		30.00
31.00	Employee discount days - IRF			0		31.00
32.00	Labor & delivery days (see instructions)	0	105	174		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: 15-0090

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
5/30/2024 3:45 pm

Component	Full Time Equivalents	Discharges			Total All Patients		
		Nonpaid Workers	Title V	Title XVIII			Title XIX
		11.00	12.00	13.00			14.00
<b>PART I - STATISTICAL DATA</b>							
1.00			0	1,804	2,000	5,875	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)							
2.00				906	0		2.00
HMO and other (see instructions)							
3.00					0		3.00
HMO IPF Subprovider							
4.00					0		4.00
HMO IRF Subprovider							
5.00							5.00
Hospital Adults & Peds. Swing Bed SNF							
6.00							6.00
Hospital Adults & Peds. Swing Bed NF							
7.00							7.00
Total Adults and Peds. (exclude observation beds) (see instructions)							
8.00							8.00
INTENSIVE CARE UNIT							
9.00							9.00
CORONARY CARE UNIT							
10.00							10.00
BURN INTENSIVE CARE UNIT							
11.00							11.00
SURGICAL INTENSIVE CARE UNIT							
12.00							12.00
NEONATAL INTENSIVE CARE UNIT							
13.00							13.00
NURSERY							
14.00	0.00	0	1,804	2,000	5,875		14.00
Total (see instructions)							
15.00							15.00
CAH visits							
15.10							15.10
REH hours and visits							
16.00							16.00
SUBPROVIDER - IPF							
17.00	0.00	0	218	8	317		17.00
SUBPROVIDER - IRF							
18.00	0.00	0		0	0		18.00
SUBPROVIDER							
19.00							19.00
SKILLED NURSING FACILITY							
20.00							20.00
NURSING FACILITY							
21.00							21.00
OTHER LONG TERM CARE							
22.00	0.00						22.00
HOME HEALTH AGENCY							
23.00							23.00
AMBULATORY SURGICAL CENTER (D.P.)							
24.00							24.00
HOSPICE							
24.10							24.10
HOSPICE (non-distinct part)							
25.00							25.00
CMHC - CMHC							
26.00							26.00
RURAL HEALTH CLINIC							
26.25	0.00						26.25
FEDERALLY QUALIFIED HEALTH CENTER							
27.00	0.00						27.00
Total (sum of lines 14-26)							
28.00							28.00
Observation Bed Days							
29.00							29.00
Ambulance Trips							
30.00							30.00
Employee discount days (see instruction)							
31.00							31.00
Employee discount days - IRF							
32.00							32.00
Labor & delivery days (see instructions)							
32.01							32.01
Total ancillary labor & delivery room outpatient days (see instructions)							
33.00				0			33.00
LTCH non-covered days							
33.01				0			33.01
LTCH site neutral days and discharges							
34.00							34.00
Temporary Expansion COVID-19 PHE Acute Care							

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 15-0090

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

Worksheet S-3  
Part II  
Date/Time Prepared:  
5/30/2024 3:45 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	
<b>PART II - WAGE DATA</b>							
<b>SALARIES</b>							
1.00	Total salaries (see instructions)	200.00	77,968,891	0	77,968,891	1,740,923.00	44.79
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00
4.01	Physicians - Part A - Teaching		61,138	0	61,138	2,080.00	29.39
5.00	Physician and Non-Physician-Part B		7,810,504	0	7,810,504	35,334.00	221.05
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00
7.00	Interns & residents (in an approved program)	21.00	57,586	0	57,586	2,080.00	27.69
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00
9.00	SNF	44.00	0	0	0	0.00	0.00
10.00	Excluded area salaries (see instructions)		13,119,237	-107,947	13,011,290	254,239.00	51.18
<b>OTHER WAGES &amp; RELATED COSTS</b>							
11.00	Contract Labor: Direct Patient Care		7,542,122	0	7,542,122	70,212.00	107.42
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00
13.00	Contract Labor: Physician-Part A - Administrative		236,423	0	236,423	1,882.00	125.62
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00
14.01	Home office salaries		13,311,189	0	13,311,189	362,250.00	36.75
14.02	Related organization salaries		0	0	0	0.00	0.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00
16.01	Home office Physicians Part A - Teaching		0	0	0	0.00	0.00
16.02	Home office contract Physicians Part A - Teaching		0	0	0	0.00	0.00
<b>WAGE-RELATED COSTS</b>							
17.00	Wage-related costs (core) (see instructions)		16,548,951	0	16,548,951		
18.00	Wage-related costs (other) (see instructions)						
19.00	Excluded areas		3,372,388	0	3,372,388		
20.00	Non-physician anesthetist Part A		0	0	0		
21.00	Non-physician anesthetist Part B		0	0	0		
22.00	Physician Part A - Administrative		0	0	0		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		1,415,732	0	1,415,732		
24.00	Wage-related costs (RHC/FQHC)		0	0	0		
25.00	Interns & residents (in an approved program)		0	0	0		
25.50	Home office wage-related (core)		4,321,961	0	4,321,961		
25.51	Related organization wage-related (core)		0	0	0		
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0		
25.53	Home office: Physicians Part A - Teaching - wage-related (core)		0	0	0		



HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 15-0090

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

Worksheet S-3  
Part II  
Date/Time Prepared:  
5/30/2024 3:45 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		
<b>OVERHEAD COSTS - DIRECT SALARIES</b>								
26.00	Employee Benefits Department	4.00	-392,931	801,851	408,920	28,562.00	14.32	26.00
27.00	Administrative & General	5.00	4,870,818	-801,851	4,068,967	92,019.00	44.22	27.00
28.00	Administrative & General under contract (see inst.)		1,346,701	0	1,346,701	8,462.00	159.15	28.00
29.00	Maintenance & Repairs	6.00	2,062,403	0	2,062,403	39,847.00	51.76	29.00
30.00	Operation of Plant	7.00	361,574	0	361,574	22,154.00	16.32	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	1,982,841	0	1,982,841	107,663.00	18.42	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	1,176,951	-663,234	513,717	24,326.00	21.12	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	663,234	663,234	31,406.00	21.12	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	2,802,259	0	2,802,259	48,650.00	57.60	38.00
39.00	Central Services and Supply	14.00	469,781	0	469,781	17,629.00	26.65	39.00
40.00	Pharmacy	15.00	2,083,852	114,462	2,198,314	42,074.00	52.25	40.00
41.00	Medical Records & Medical Records Library	16.00	264,666	0	264,666	6,611.00	40.03	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: 15-0090

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

Worksheet S-3  
Part III  
Date/Time Prepared:  
5/30/2024 3:45 pm

	Worksheet A Line Number	Amount Reported	Recl assi fi cati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col . 2 ± col . 3)	Paid Hours Related to Salaries in col . 4	Average Hourly Wage (col . 4 ÷ col . 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
<b>PART III - HOSPITAL WAGE INDEX SUMMARY</b>							
1.00	Net salaries (see instructions)	71,386,364	0	71,386,364	1,709,891.00	41.75	1.00
2.00	Excluded area salaries (see instructions)	13,119,237	-107,947	13,011,290	254,239.00	51.18	2.00
3.00	Subtotal salaries (line 1 minus line 2)	58,267,127	107,947	58,375,074	1,455,652.00	40.10	3.00
4.00	Subtotal other wages & related costs (see inst.)	21,089,734	0	21,089,734	434,344.00	48.56	4.00
5.00	Subtotal wage-related costs (see inst.)	20,870,912	0	20,870,912	0.00	35.75	5.00
6.00	Total (sum of lines 3 thru 5)	100,227,773	107,947	100,335,720	1,889,996.00	53.09	6.00
7.00	Total overhead cost (see instructions)	17,028,915	114,462	17,143,377	469,403.00	36.52	7.00

HOSPITAL WAGE RELATED COSTS	Provider CCN: 15-0090	Period: From 01/01/2023 To 12/31/2023	Worksheet S-3 Part IV Date/Time Prepared: 5/30/2024 3:45 pm
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		Amount Reported	
		1.00	
<b>PART IV - WAGE RELATED COSTS</b>			
<b>Part A - Core List</b>			
<b>RETIREMENT COST</b>			
1.00	401K Employer Contributions	2,144,512	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)	4,947,634	4.00
<b>PLAN ADMINISTRATIVE COSTS (Paid to External Organization)</b>			
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
<b>HEALTH AND INSURANCE COST</b>			
8.00	Health Insurance (Purchased or Self Funded)	0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	7,340,154	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	270,565	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	29,248	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)	293,826	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	1,101,174	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Noncumulative portion)	0	16.00
<b>TAXES</b>			
17.00	FICA-Employers Portion Only	5,209,958	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
<b>OTHER</b>			
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)	21,337,071	24.00
<b>Part B - Other than Core Related Cost</b>			
25.00	OTHER WAGE RELATED COSTS (SPECIFY)		25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST		Provider CCN: 15-0090	Period: From 01/01/2023 To 12/31/2023	Worksheet S-3 Part V Date/Time Prepared: 5/30/2024 3:45 pm
Cost Center Description		Contract Labor	Benefit Cost	
PART V - Contract Labor and Benefit Cost		1.00	2.00	
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost	8,205,671	21,337,071	1.00
2.00	Hospital	8,205,671	21,337,071	2.00
3.00	SUBPROVIDER - IPF			3.00
4.00	SUBPROVIDER - IRF	0	0	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	0	0	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	0	18.00

HOME HEALTH AGENCY STATISTICAL DATA		Provider CCN: 15-0090 Component CCN: 15-7145	Period: From 01/01/2023 To 12/31/2023	Worksheet S-4 Date/Time Prepared: 5/30/2024 3:45 pm
			Home Health Agency I	PPS

					1.00	
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0.00	County						0.00
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		Title V	Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	5.00	
HOME HEALTH AGENCY STATISTICAL DATA							
1.00	Home Health Aide Hours	0	38,945	2,706	7,517	49,168	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	1,365.00	3,088.00	8,337.00	56,477.00	2.00
		Number of Employees (Full Time Equivalent)					
		Enter the number of hours in your normal work week			Staff	Contract	Total
		0	1.00	2.00	3.00		

HOME HEALTH AGENCY - NUMBER OF EMPLOYEES							
3.00	Administrator and Assistant Administrator(s)		0.00	0.00	0.13	0.13	3.00
4.00	Director(s) and Assistant Director(s)			0.50	0.00	0.50	4.00
5.00	Other Administrative Personnel			21.43	0.00	21.43	5.00
6.00	Direct Nursing Service			7.57	0.21	7.78	6.00
7.00	Nursing Supervisor			3.02	0.00	3.02	7.00
8.00	Physical Therapy Service			0.00	1.08	1.08	8.00
9.00	Physical Therapy Supervisor			0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service			0.87	0.40	1.27	10.00
11.00	Occupational Therapy Supervisor			0.60	0.00	0.60	11.00
12.00	Speech Pathology Service			0.00	0.11	0.11	12.00
13.00	Speech Pathology Supervisor			0.00	0.00	0.00	13.00
14.00	Medical Social Service			0.00	0.01	0.01	14.00
15.00	Medical Social Service Supervisor			0.00	0.00	0.00	15.00
16.00	Home Health Aide			0.00	0.00	0.00	16.00
17.00	Home Health Aide Supervisor			0.00	0.00	0.00	17.00
18.00	PTA - PHYSICAL THERAPY ASSISTANT			0.00	0.54	0.54	18.00

						CBSA Data	
						1.00	

HOME HEALTH AGENCY CBSA CODES							
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.					5	19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).					16984	20.00
20.01						23844	20.01
20.02						33140	20.02
20.03						43780	20.03
20.04						99915	20.04

		Full Episodes		LUPA Episodes	PEP Only Episodes	Total (col s. 1-4)	
		Without Outliers	With Outliers				
		1.00	2.00	3.00	4.00	5.00	

PPS ACTIVITY DATA							
21.00	Skilled Nursing Visits	8,515	1,409	219	19	10,162	21.00
22.00	Skilled Nursing Visit Charges	3,397,485	562,191	86,982	7,581	4,054,239	22.00
23.00	Physical Therapy Visits	8,937	1,552	79	25	10,593	23.00
24.00	Physical Therapy Visit Charges	3,699,918	642,528	32,706	10,350	4,385,502	24.00
25.00	Occupational Therapy Visits	985	817	6	2	1,810	25.00
26.00	Occupational Therapy Visit Charges	407,790	338,238	2,484	828	749,340	26.00
27.00	Speech Pathology Visits	108	70	0	0	178	27.00
28.00	Speech Pathology Visit Charges	44,712	28,980	0	0	73,692	28.00
29.00	Medical Social Service Visits	7	7	0	1	15	29.00
30.00	Medical Social Service Visit Charges	3,360	3,360	0	480	7,200	30.00
31.00	Home Health Aide Visits	744	304	3	0	1,051	31.00
32.00	Home Health Aide Visit Charges	143,592	58,672	579	0	202,843	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	19,296	4,159	307	47	23,809	33.00
34.00	Other Charges	0	0	0	0	0	34.00
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	7,696,857	1,633,969	122,751	19,239	9,472,816	35.00
36.00	Total Number of Episodes (standard/non outlier)	2,426		196	8	2,630	36.00
37.00	Total Number of Outlier Episodes		230		1	231	37.00
38.00	Total Non-Routine Medical Supply Charges	122,745	22,620	2,280	110	147,755	38.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 15-0090	Period: From 01/01/2023 To 12/31/2023	Worksheet S-10 Parts I & II Date/Time Prepared: 5/30/2024 3:45 pm	
				1.00	
<b>PART I - HOSPITAL AND HOSPITAL COMPLEX DATA</b>					
<b>Uncompensated and Indigent Care Cost-to-Charge Ratio</b>					
1.00	Cost to charge ratio (see instructions)			0.236961	1.00
<b>Medicaid (see instructions for each line)</b>					
2.00	Net revenue from Medicaid			25,155,717	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			0	5.00
6.00	Medicaid charges			140,359,693	6.00
7.00	Medicaid cost (line 1 times line 6)			33,259,773	7.00
8.00	Difference between net revenue and costs for Medicaid program (see instructions)			8,104,056	8.00
<b>Children's Health Insurance Program (CHIP) (see instructions for each line)</b>					
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
<b>Other state or local government indigent care program (see instructions for each line)</b>					
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
<b>Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)</b>					
17.00	Private grants, donations, or endowment income restricted to funding charity care			0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations			0	18.00
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)			8,104,056	19.00
		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
<b>Uncompensated care cost (see instructions for each line)</b>					
20.00	Charity care charges and uninsured discounts (see instructions)	10,155,094	2,996,594	13,151,688	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	2,406,361	2,996,594	5,402,955	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)	2,406,361	2,996,594	5,402,955	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)			0	25.01
26.00	Bad debt amount (see instructions)			4,548,715	26.00
27.00	Medicare reimbursable bad debts (see instructions)			290,029	27.00
27.01	Medicare allowable bad debts (see instructions)			446,198	27.01
28.00	Non-Medicare bad debt amount (see instructions)			4,102,517	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)			1,128,306	29.00
30.00	Cost of uncompensated care (line 23, col. 3, plus line 29)			6,531,261	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			14,635,317	31.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 15-0090	Period: From 01/01/2023 To 12/31/2023	Worksheet S-10 Parts I & II Date/Time Prepared: 5/30/2024 3:45 pm
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				1.00		
<b>PART II - HOSPITAL DATA</b>						
<b>Uncompensated and Indigent Care Cost-to-Charge Ratio</b>						
1.00	Cost to charge ratio (see instructions)			0.218578	1.00	
<b>Medicaid (see instructions for each line)</b>						
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	
<b>Children's Health Insurance Program (CHIP) (see instructions for each line)</b>						
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	
<b>Other state or local government indigent care program (see instructions for each line)</b>						
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	
<b>Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)</b>						
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
<b>Uncompensated care cost (see instructions for each line)</b>						
20.00	Charity care charges and uninsured discounts (see instructions)	10,113,056	2,983,695	13,096,751	20.00	
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	2,210,492	2,983,695	5,194,187	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)	2,210,492	2,983,695	5,194,187	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)			0	25.01	
26.00	Bad debt amount (see instructions)			4,517,688	26.00	
27.00	Medicare reimbursable bad debts (see instructions)			290,029	27.00	
27.01	Medicare allowable bad debts (see instructions)			446,198	27.01	
28.00	Non-Medicare bad debt amount (see instructions)			4,071,490	28.00	
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)			1,046,107	29.00	
30.00	Cost of uncompensated care (line 23, col. 3, plus line 29)			6,240,294	30.00	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			6,240,294	31.00	

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES				Provider CCN: 15-0090	Period: From 01/01/2023 To 12/31/2023	Worksheet A Date/Time Prepared: 5/30/2024 3:45 pm	
Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassified Trial Balance (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)		
	1.00	2.00	3.00	4.00	5.00		
<b>GENERAL SERVICE COST CENTERS</b>							
1.00 00100	CAP REL COSTS-BLDG & FIXT	0	0	7,079,937	7,079,937	1.00	
2.00 00200	CAP REL COSTS-MVBLE EQUIP	0	0	4,544,448	4,544,448	2.00	
3.00 00300	OTHER CAP REL COSTS	0	0	0	0	3.00	
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	-392,931	19,446,342	19,053,411	789,867	19,843,278	4.00
5.04 00593	OTHER ADMINISTRATIVE AND GENERAL	4,870,818	45,637,320	50,508,138	-2,944,320	47,563,818	5.04
6.00 00600	MAINTENANCE & REPAIRS	2,062,403	7,449,913	9,512,316	-2,743,063	6,769,253	6.00
7.00 00700	OPERATION OF PLANT	361,574	4,420,884	4,782,458	-2,152,906	2,629,552	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	642,351	642,351	0	642,351	8.00
9.00 00900	HOUSEKEEPING	1,982,841	417,231	2,400,072	-7,970	2,392,102	9.00
10.00 01000	DIETARY	1,176,951	1,174,006	2,350,957	-1,329,766	1,021,191	10.00
11.00 01100	CAFETERIA	0	0	0	1,318,409	1,318,409	11.00
13.00 01300	NURSING ADMINISTRATION	2,802,259	1,521,606	4,323,865	-120,646	4,203,219	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	469,781	894,953	1,364,734	-562,814	801,920	14.00
15.00 01500	PHARMACY	2,083,852	4,339,557	6,423,409	-4,115,704	2,307,705	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	264,666	247,472	512,138	0	512,138	16.00
17.00 01700	SOCIAL SERVICE	0	0	0	0	0	17.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD	57,586	571	58,157	0	58,157	21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRV	61,138	73,646	134,784	0	134,784	22.00
23.00 02300	PARAMED PRGM - EMERGENCY MEDICINE	620	66,577	67,197	5,780	72,977	23.00
23.01 02301	PARAMED PRGM- LAB	93,100	9,748	102,848	167,651	270,499	23.01
23.02 02302	PARAMED PRGM- PHARMACY	323,628	10,867	334,495	-114,462	220,033	23.02
23.03 02303	PARAMED PRGM- RADIOLOGY	0	0	0	0	0	23.03
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00 03000	ADULTS & PEDIATRICS	20,391,668	7,383,158	27,774,826	-1,873,032	25,901,794	30.00
31.00 03100	INTENSIVE CARE UNIT	2,215,277	980,649	3,195,926	-442,715	2,753,211	31.00
32.00 03200	CORONARY CARE UNIT	0	0	0	0	0	32.00
33.00 03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
35.00 02060	NEONATAL INTENSIVE CARE UNIT	1,092,012	938,860	2,030,872	-718,270	1,312,602	35.00
41.00 04100	SUBPROVIDER - I RF	2,480,378	460,479	2,940,857	-177,252	2,763,605	41.00
42.00 04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00 04300	NURSERY	0	0	0	1,144,319	1,144,319	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00 05000	OPERATING ROOM	1,183,725	9,327,018	10,510,743	-7,263,206	3,247,537	50.00
50.01 05001	OUTPATIENT SURGERY	816,070	393,429	1,209,499	-325,049	884,450	50.01
51.00 05100	RECOVERY ROOM	461,869	48,314	510,183	-45,683	464,500	51.00
53.00 05300	ANESTHESIOLOGY	38,551	4,174,460	4,213,011	-260,044	3,952,967	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	1,835,392	1,913,827	3,749,219	-1,129,603	2,619,616	54.00
54.01 05401	RADIOLOGY-SPECIAL PROCEDURES	1,270,962	1,065,325	2,336,287	-964,391	1,371,896	54.01
55.00 05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00 05600	RADIO SOTOPE	300,678	346,825	647,503	-274,255	373,248	56.00
60.00 06000	LABORATORY	0	7,538,719	7,538,719	-198,562	7,340,157	60.00
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	0	394,878	394,878	0	394,878	63.00
65.00 06500	RESPIRATORY THERAPY	1,737,405	937,133	2,674,538	-276,995	2,397,543	65.00
66.00 06600	PHYSICAL THERAPY	3,656,986	636,523	4,293,509	-516,067	3,777,442	66.00
67.00 06700	OCCUPATIONAL THERAPY	569,246	2,212	571,458	-157	571,301	67.00
68.00 06800	SPEECH PATHOLOGY	445,734	174,663	620,397	-57,570	562,827	68.00
69.00 06900	ELECTROCARDIOLOGY	858,559	210,798	1,069,357	-184,320	885,037	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	236,979	19,287	256,266	-17,024	239,242	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	13,382,669	13,382,669	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	3,546,940	3,546,940	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	4,618,938	4,618,938	73.00
76.00 03630	ULTRA SOUND	571,075	111,878	682,953	-86,501	596,452	76.00
76.01 03951	PAIN CLINIC	640,263	105,540	745,803	-94,460	651,343	76.01
76.02 03952	CATH LAB	2,091,847	6,370,756	8,462,603	-6,168,447	2,294,156	76.02
76.03 03953	ACTIVITY THERAPEUTIC	1,582,792	30,756	1,613,548	-324	1,613,224	76.03
76.04 03954	WOUND CARE CENTER	561,329	136,130	697,459	-127,851	569,608	76.04
76.05 03340	BARITRIC CLINIC	1,500,713	16,974	1,517,687	-10,773	1,506,914	76.05
76.06 03030	HEALTHY LIVING CENTER	0	0	0	0	0	76.06
76.07 03950	CV RESOURCE CENTER	0	0	0	0	0	76.07
76.08 03955	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.08
76.09 03956	LACTATION CLINIC	0	0	0	0	0	76.09
76.10 03957	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.10
76.11 03958	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.11
76.12 03959	ANTI COAGULATION CLINIC	596,801	55,174	651,975	-51,388	600,587	76.12
77.00 07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77.00
78.00 07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
91.00 09100	EMERGENCY	4,392,783	2,274,521	6,667,304	-854,568	5,812,736	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
101.00 10100	HOME HEALTH AGENCY	7,070,212	1,425,363	8,495,575	-412,059	8,083,516	101.00



RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 15-0090

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

Worksheet A

Date/Time Prepared:  
5/30/2024 3:45 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			
102.00	10200	0	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300		-25,974	-25,974	25,974	0	113.00
118.00							
SUBTOTALS (SUM OF LINES 1 through 117)		74,817,592	133,800,719	208,618,311	2,715	208,621,026	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	50,509	114,923	165,432	0	165,432	190.00
192.00	19200	485,703	-15,145	470,558	29	470,587	192.00
192.01	19201	0	0	0	0	0	192.01
192.02	19202	0	0	0	0	0	192.02
192.03	19203	0	0	0	0	0	192.03
194.00	07950	2,614,086	175,416	2,789,502	-2,744	2,786,758	194.00
194.01	07954	0	40	40	0	40	194.01
194.02	07952	0	0	0	0	0	194.02
194.03	07953	1,001	369	1,370	0	1,370	194.03
200.00		77,968,891	134,076,322	212,045,213	0	212,045,213	200.00
TOTAL (SUM OF LINES 118 through 199)							

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 15-0090

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

Worksheet A  
Date/Time Prepared:  
5/30/2024 3:45 pm

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
<b>GENERAL SERVICE COST CENTERS</b>					
1.00	00100	CAP REL COSTS-BLDG & FIXT	1,498,189	8,578,126	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	4,544,448	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,570,802	21,414,080	4.00
5.04	00593	OTHER ADMINISTRATIVE AND GENERAL	-7,153,902	40,409,916	5.04
6.00	00600	MAINTENANCE & REPAIRS	-3,848	6,765,405	6.00
7.00	00700	OPERATION OF PLANT	-908,650	1,720,902	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	642,351	8.00
9.00	00900	HOUSEKEEPING	0	2,392,102	9.00
10.00	01000	DIETARY	-1,505	1,019,686	10.00
11.00	01100	CAFETERIA	-449,526	868,883	11.00
13.00	01300	NURSING ADMINISTRATION	-1,369,118	2,834,101	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	801,920	14.00
15.00	01500	PHARMACY	304,817	2,612,522	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	858,423	1,370,561	16.00
17.00	01700	SOCIAL SERVICE	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	58,157	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	-27,736	107,048	22.00
23.00	02300	PARAMED ED PRGM - EMERGENCY MEDICINE	-1,250	71,727	23.00
23.01	02301	PARAMED ED PRGM- LAB	0	270,499	23.01
23.02	02302	PARAMED ED PRGM- PHARMACY	0	220,033	23.02
23.03	02303	PARAMED ED PRGM- RADIOLOGY	0	0	23.03
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS	-6,624,829	19,276,965	30.00
31.00	03100	INTENSIVE CARE UNIT	0	2,753,211	31.00
32.00	03200	CORONARY CARE UNIT	0	0	32.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	33.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	-809,876	502,726	35.00
41.00	04100	SUBPROVIDER - I RF	-848,491	1,915,114	41.00
42.00	04200	SUBPROVIDER	0	0	42.00
43.00	04300	NURSERY	0	1,144,319	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	-14,580	3,232,957	50.00
50.01	05001	OUTPATIENT SURGERY	0	884,450	50.01
51.00	05100	RECOVERY ROOM	-40	464,460	51.00
53.00	05300	ANESTHESIOLOGY	-3,935,238	17,729	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-71	2,619,545	54.00
54.01	05401	RADIOLOGY-SPECIAL PROCEDURES	0	1,371,896	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	55.00
56.00	05600	RADIOISOTOPE	0	373,248	56.00
60.00	06000	LABORATORY	-35,363	7,304,794	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	394,878	63.00
65.00	06500	RESPIRATORY THERAPY	-23,021	2,374,522	65.00
66.00	06600	PHYSICAL THERAPY	0	3,777,442	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	571,301	67.00
68.00	06800	SPEECH PATHOLOGY	0	562,827	68.00
69.00	06900	ELECTROCARDIOLOGY	0	885,037	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	239,242	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	13,382,669	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	3,546,940	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	4,618,938	73.00
76.00	03630	ULTRA SOUND	-5	596,447	76.00
76.01	03951	PAIN CLINIC	0	651,343	76.01
76.02	03952	CATH LAB	-1,000	2,293,156	76.02
76.03	03953	ACTIVITY THERAPEUTIC	-19,951	1,593,273	76.03
76.04	03954	WOUND CARE CENTER	0	569,608	76.04
76.05	03340	BARITRIC CLINIC	-947,500	559,414	76.05
76.06	03030	HEALTHY LIVING CENTER	0	0	76.06
76.07	03950	CV RESOURCE CENTER	0	0	76.07
76.08	03955	OTHER ANCILLARY SERVICE COST CENTERS	0	0	76.08
76.09	03956	LACTATION CLINIC	0	0	76.09
76.10	03957	OTHER ANCILLARY SERVICE COST CENTERS	0	0	76.10
76.11	03958	OTHER ANCILLARY SERVICE COST CENTERS	0	0	76.11
76.12	03959	ANTI COAGULATION CLINIC	-19,273	581,314	76.12
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	78.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
91.00	09100	EMERGENCY	-722,050	5,090,686	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
101.00	10100	HOME HEALTH AGENCY	0	8,083,516	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	102.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 15-0090

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

Worksheet A  
Date/Time Prepared:  
5/30/2024 3:45 pm

Cost Center Description		Adjustments (See A-8) 6.00	Net Expenses For Allocation 7.00		
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-19,684,592	188,936,434	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	165,432	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	-131,200	339,387	192.00
192.01	19201	WORKING WELL	0	0	192.01
192.02	19202	PHYSICIANS' PRIVATE OFFICES	0	0	192.02
192.03	19203	MISC	0	0	192.03
194.00	07950	RESIDENTIAL	0	2,786,758	194.00
194.01	07954	OTHER NONREIMBURSABLE COST CENTERS	0	40	194.01
194.02	07952	PSYCHIATRIC	0	0	194.02
194.03	07953	CENTER OF HOPE	0	1,370	194.03
200.00		TOTAL (SUM OF LINES 118 through 199)	-19,815,792	192,229,421	200.00

RECLASSIFICATIONS

Provider CCN: 15-0090

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

Worksheet A-6  
Date/Time Prepared:  
5/30/2024 3:45 pm

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
<b>A - DEPRECIATION</b>					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	5,686,657	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	3,799,560	2.00
3.00	NURSING ADMINISTRATION	13.00	0	5,920	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
25.00		0.00	0	0	25.00
26.00		0.00	0	0	26.00
27.00		0.00	0	0	27.00
28.00		0.00	0	0	28.00
29.00		0.00	0	0	29.00
30.00		0.00	0	0	30.00
31.00		0.00	0	0	31.00
32.00		0.00	0	0	32.00
33.00		0.00	0	0	33.00
34.00		0.00	0	0	34.00
0			0	9,492,137	
<b>B - INTEREST CAPITALIZED</b>					
1.00	INTEREST EXPENSE	113.00	0	25,974	1.00
0			0	25,974	
<b>C - DIETARY</b>					
1.00	CAFETERIA	11.00	663,234	655,175	1.00
0			663,234	655,175	
<b>D - INSURANCE</b>					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	747,004	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	207,648	2.00
0			0	954,652	
<b>E - PATIENT TRANSPORT</b>					
1.00	ADULTS & PEDIATRICS	30.00	16,493	19	1.00
2.00	RADIOLOGY-DIAGNOSTIC	54.00	92,022	106	2.00
3.00	RADIOISOTOPE	56.00	27,966	32	3.00
4.00	ELECTROCARDIOLOGY	69.00	6,451	7	4.00
5.00	ULTRASOUND	76.00	11,473	13	5.00
6.00	CATH LAB	76.02	6,092	7	6.00
7.00	EMERGENCY	91.00	10,240	12	7.00
8.00	PHYSICIANS' PRIVATE OFFICES	192.00	478	1	8.00
0			171,215	197	
<b>F - CHARGEABLE MED SUPPLIES &amp; IMPLANTS</b>					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	13,382,669	1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	3,546,940	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
25.00		0.00	0	0	25.00
26.00		0.00	0	0	26.00
27.00		0.00	0	0	27.00
28.00		0.00	0	0	28.00
29.00		0.00	0	0	29.00
30.00		0.00	0	0	30.00
31.00		0.00	0	0	31.00
0			0	16,929,609	
<b>G - DRUGS CHARGED TO PATIENTS</b>					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	4,618,938	1.00
2.00	CENTRAL SERVICES & SUPPLY	14.00	0	656	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
0			0	4,619,594	
<b>H - PARAMEDICAL</b>					
1.00	PARAMED ED PRGM - EMERGENCY MEDICINE	23.00	6,037	0	1.00
2.00	PARAMED ED PRGM- LAB	23.01	0	168,324	2.00
3.00	PHARMACY	15.00	114,462	0	3.00
0			120,499	168,324	
<b>I - NURSERY</b>					
1.00	NEONATAL INTENSIVE CARE UNIT	35.00	2,340	148	1.00
2.00	NURSERY	43.00	811,821	332,498	2.00
0			814,161	332,646	
<b>J - OPEN</b>					
1.00		0.00	0	0	1.00
0			0	0	
<b>K - LEASES AND RENT</b>					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	672,250	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	537,240	2.00
3.00	CENTRAL SERVICES & SUPPLY	14.00	0	7,960	3.00
4.00	RADIOLOGY-SPECIAL PROCEDURES	54.01	0	1,950	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
0			0	1,219,400	

RECLASSIFICATIONS

Provider CCN: 15-0090

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

Worksheet A-6  
Date/Time Prepared:  
5/30/2024 3:45 pm

		Increases			
Cost Center		Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
L - PTO RECLASS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	801,851	0	1.00
	TOTALS		801,851	0	
500.00	Grand Total: Increases		2,570,960	34,397,708	500.00

RECLASSIFICATIONS

Provider CCN: 15-0090

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

Worksheet A-6  
Date/Time Prepared:  
5/30/2024 3:45 pm

		Decreases					
Cost Center		Line #	Salary	Other	Wkst. A-7 Ref.		
6.00		7.00	8.00	9.00	10.00		
<b>A - DEPRECIATION</b>							
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1,994	9		1.00
2.00	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	1,033,504	9		2.00
3.00	MAINTENANCE & REPAIRS	6.00	0	2,733,427	0		3.00
4.00	OPERATION OF PLANT	7.00	0	2,150,652	0		4.00
5.00	HOUSEKEEPING	9.00	0	7,970	0		5.00
6.00	DIETARY	10.00	0	11,357	0		6.00
7.00	CENTRAL SERVICES & SUPPLY	14.00	0	132,464	0		7.00
8.00	PHARMACY	15.00	0	29,763	0		8.00
9.00	PARAMED ED PRGM- LAB	23.01	0	373	0		9.00
10.00	ADULTS & PEDIATRICS	30.00	0	343,898	0		10.00
11.00	INTENSIVE CARE UNIT	31.00	0	69,512	0		11.00
12.00	NEONATAL INTENSIVE CARE UNIT	35.00	0	8,340	0		12.00
13.00	SUBPROVIDER - IRF	41.00	0	23,024	0		13.00
14.00	OPERATING ROOM	50.00	0	807,176	0		14.00
15.00	OUTPATIENT SURGERY	50.01	0	21,854	0		15.00
16.00	RECOVERY ROOM	51.00	0	37,055	0		16.00
17.00	ANESTHESIOLOGY	53.00	0	633	0		17.00
18.00	RADIOLOGY-DIAGNOSTIC	54.00	0	1,005,345	0		18.00
19.00	RADIOLOGY-SPECIAL PROCEDURES	54.01	0	68,585	0		19.00
20.00	RADIOISOTOPE	56.00	0	149,760	0		20.00
21.00	LABORATORY	60.00	0	30,172	0		21.00
22.00	RESPIRATORY THERAPY	65.00	0	79,882	0		22.00
23.00	PHYSICAL THERAPY	66.00	0	68,481	0		23.00
24.00	SPEECH PATHOLOGY	68.00	0	22,138	0		24.00
25.00	ELECTROCARDIOLOGY	69.00	0	160,210	0		25.00
26.00	ELECTROENCEPHALOGRAPHY	70.00	0	3,264	0		26.00
27.00	ULTRA SOUND	76.00	0	76,234	0		27.00
28.00	PAIN CLINIC	76.01	0	16,677	0		28.00
29.00	CATH LAB	76.02	0	292,665	0		29.00
30.00	ACTIVITY THERAPEUTIC	76.03	0	300	0		30.00
31.00	WOUND CARE CENTER	76.04	0	5,335	0		31.00
32.00	BARIATRIC CLINIC	76.05	0	8,286	0		32.00
33.00	EMERGENCY	91.00	0	60,317	0		33.00
34.00	HOME HEALTH AGENCY	101.00	0	31,490	0		34.00
<b>O</b>							
<b>B - INTEREST CAPITALIZED</b>							
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	25,974	11		1.00
<b>O</b>							
<b>C - DIETARY</b>							
1.00	DIETARY	10.00	663,234	655,175	0		1.00
<b>O</b>							
<b>D - INSURANCE</b>							
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	954,652	12		1.00
2.00		0.00	0	0	12		2.00
<b>O</b>							
<b>E - PATIENT TRANSPORT</b>							
1.00	EMERGENCY	91.00	171,215	197	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
<b>O</b>							
<b>F - CHARGEABLE MED SUPPLIES &amp; IMPLANTS</b>							
1.00	NURSING ADMINISTRATION	13.00	0	116,545	0		1.00
2.00	CENTRAL SERVICES & SUPPLY	14.00	0	438,966	0		2.00
3.00	PHARMACY	15.00	0	65,775	0		3.00
4.00	PARAMED ED PRGM - EMERGENCY MEDICINE	23.00	0	257	0		4.00
5.00	ADULTS & PEDIATRICS	30.00	0	956,134	0		5.00
6.00	INTENSIVE CARE UNIT	31.00	0	328,567	0		6.00
7.00	NEONATAL INTENSIVE CARE UNIT	35.00	0	37,034	0		7.00
8.00	SUBPROVIDER - IRF	41.00	0	63,068	0		8.00
9.00	OPERATING ROOM	50.00	0	6,007,721	0		9.00
10.00	OUTPATIENT SURGERY	50.01	0	296,702	0		10.00
11.00	RECOVERY ROOM	51.00	0	7,419	0		11.00
12.00	ANESTHESIOLOGY	53.00	0	194,587	0		12.00
13.00	RADIOLOGY-DIAGNOSTIC	54.00	0	213,884	0		13.00
14.00	RADIOLOGY-SPECIAL PROCEDURES	54.01	0	895,431	0		14.00

RECLASSIFICATIONS

Provider CCN: 15-0090

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

Worksheet A-6  
Date/Time Prepared:  
5/30/2024 3:45 pm

Decreases							
Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.			
6.00	7.00	8.00	9.00	10.00			
15.00	RADIO SOTOPE	56.00	0	9,861	0	15.00	
16.00	LABORATORY	60.00	0	66	0	16.00	
17.00	RESPIRATORY THERAPY	65.00	0	192,809	0	17.00	
18.00	PHYSICAL THERAPY	66.00	0	13,721	0	18.00	
19.00	OCCUPATIONAL THERAPY	67.00	0	157	0	19.00	
20.00	SPEECH PATHOLOGY	68.00	0	35,432	0	20.00	
21.00	ELECTROCARDIOLOGY	69.00	0	30,536	0	21.00	
22.00	ELECTROENCEPHALOGRAPHY	70.00	0	13,760	0	22.00	
23.00	ULTRA SOUND	76.00	0	21,680	0	23.00	
24.00	PAIN CLINIC	76.01	0	77,110	0	24.00	
25.00	CATH LAB	76.02	0	5,875,307	0	25.00	
26.00	ACTIVITY THERAPEUTIC	76.03	0	24	0	26.00	
27.00	WOUND CARE CENTER	76.04	0	106,224	0	27.00	
28.00	BARIATRIC CLINIC	76.05	0	2,428	0	28.00	
29.00	ANTI COAGULATION CLINIC	76.12	0	51,388	0	29.00	
30.00	EMERGENCY	91.00	0	591,923	0	30.00	
31.00	HOME HEALTH AGENCY	101.00	0	285,093	0	31.00	
	<b>O</b>			<b>16,929,609</b>			
<b>G - DRUGS CHARGED TO PATIENTS</b>							
1.00	NURSING ADMINISTRATION	13.00	0	33	0	1.00	
2.00	PHARMACY	15.00	0	4,110,859	0	2.00	
3.00	PARAMED ED PRGM- LAB	23.01	0	300	0	3.00	
4.00	ADULTS & PEDIATRICS	30.00	0	70,825	0	4.00	
5.00	INTENSIVE CARE UNIT	31.00	0	39,404	0	5.00	
6.00	NEONATAL INTENSIVE CARE UNIT	35.00	0	150	0	6.00	
7.00	SUBPROVIDER - IRF	41.00	0	87,340	0	7.00	
8.00	OPERATING ROOM	50.00	0	23,641	0	8.00	
9.00	OUTPATIENT SURGERY	50.01	0	6,493	0	9.00	
10.00	RECOVERY ROOM	51.00	0	1,209	0	10.00	
11.00	ANESTHESIOLOGY	53.00	0	64,824	0	11.00	
12.00	RADIOLOGY-DIAGNOSTIC	54.00	0	2,502	0	12.00	
13.00	RADIOLOGY-SPECIAL PROCEDURES	54.01	0	2,325	0	13.00	
14.00	RADIO SOTOPE	56.00	0	142,632	0	14.00	
15.00	LABORATORY	60.00	0	0	0	15.00	
16.00	RESPIRATORY THERAPY	65.00	0	2,372	0	16.00	
17.00	ELECTROCARDIOLOGY	69.00	0	32	0	17.00	
18.00	ULTRA SOUND	76.00	0	73	0	18.00	
19.00	PAIN CLINIC	76.01	0	673	0	19.00	
20.00	CATH LAB	76.02	0	6,574	0	20.00	
21.00	WOUND CARE CENTER	76.04	0	16,292	0	21.00	
22.00	BARIATRIC CLINIC	76.05	0	59	0	22.00	
23.00	EMERGENCY	91.00	0	35,131	0	23.00	
24.00	HOME HEALTH AGENCY	101.00	0	5,851	0	24.00	
	<b>O</b>			<b>4,619,594</b>			
<b>H - PARAMEDICAL</b>							
1.00	EMERGENCY	91.00	6,037	0	0	1.00	
2.00	LABORATORY	60.00	0	168,324	0	2.00	
3.00	PARAMED ED PRGM- PHARMACY	23.02	114,462	0	0	3.00	
	<b>O</b>		<b>120,499</b>	<b>168,324</b>			
<b>I - NURSERY</b>							
1.00	ADULTS & PEDIATRICS	30.00	443,457	28,116	0	1.00	
2.00	NEONATAL INTENSIVE CARE UNIT	35.00	370,704	304,530	0	2.00	
	<b>O</b>		<b>814,161</b>	<b>332,646</b>			
<b>J - OPEN</b>							
1.00		0.00	0	0	0	1.00	
	<b>O</b>		<b>0</b>	<b>0</b>			
<b>K - LEASES AND RENT</b>							
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	9,990	10	1.00	
2.00	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	154,313	10	2.00	
3.00	MAINTENANCE & REPAIRS	6.00	0	9,636	0	3.00	
4.00	OPERATION OF PLANT	7.00	0	2,254	0	4.00	
5.00	NURSING ADMINISTRATION	13.00	0	9,988	0	5.00	
6.00	PHARMACY	15.00	0	23,769	0	6.00	
7.00	ADULTS & PEDIATRICS	30.00	0	47,114	0	7.00	
8.00	INTENSIVE CARE UNIT	31.00	0	5,232	0	8.00	
9.00	SUBPROVIDER - IRF	41.00	0	3,820	0	9.00	
10.00	OPERATING ROOM	50.00	0	424,668	0	10.00	
11.00	RESPIRATORY THERAPY	65.00	0	1,932	0	11.00	
12.00	PHYSICAL THERAPY	66.00	0	433,865	0	12.00	
13.00	WOUND CARE CENTER	76.04	0	0	0	13.00	
14.00	HOME HEALTH AGENCY	101.00	0	89,625	0	14.00	
15.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	450	0	15.00	
16.00	RESIDENTIAL	194.00	0	2,744	0	16.00	



RECLASSIFICATIONS

Provider CCN: 15-0090

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

Worksheet A-6

Date/Time Prepared:  
5/30/2024 3:45 pm

Decreases							
Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.			
6.00	7.00	8.00	9.00	10.00			
0		0	1,219,400				
L - PTO RECLASS							
1.00	5.04	801,851	0	0		1.00	
		801,851	0				
500.00	Grand Total: Decreases						500.00
		2,570,960	34,397,708				

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-0090

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

Worksheet A-7  
Part I  
Date/Time Prepared:  
5/30/2024 3:45 pm

	Beginning Balances	Acquisitions			Disposals and Retirements	
		Purchases	Donation	Total		
	1.00	2.00	3.00	4.00	5.00	
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>						
1.00	Land	694,364	0	0	0	1.00
2.00	Land Improvements	10,182,390	199,631	0	199,631	2.00
3.00	Buildings and Fixtures	71,826,630	2,782,487	0	2,782,487	3.00
4.00	Building Improvements	178,989	0	0	0	4.00
5.00	Fixed Equipment	177,456,706	1,106,417	0	1,106,417	5.00
6.00	Movable Equipment	2,347,192	170,420	0	170,420	6.00
7.00	HIT designated Assets	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	262,686,271	4,258,955	0	4,258,955	8.00
9.00	Reconciling Items	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	262,686,271	4,258,955	0	4,258,955	10.00
	Ending Balance		Fully Depreciated Assets			
	6.00		7.00			
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>						
1.00	Land	694,364	0			1.00
2.00	Land Improvements	10,382,021	5,106,643			2.00
3.00	Buildings and Fixtures	74,382,828	32,938,868			3.00
4.00	Building Improvements	178,989	178,989			4.00
5.00	Fixed Equipment	177,430,509	48,463,845			5.00
6.00	Movable Equipment	2,496,299	522,740			6.00
7.00	HIT designated Assets	0	0			7.00
8.00	Subtotal (sum of lines 1-7)	265,565,010	87,211,085			8.00
9.00	Reconciling Items	0	0			9.00
10.00	Total (line 8 minus line 9)	265,565,010	87,211,085			10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-0090

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

Worksheet A-7  
Part II  
Date/Time Prepared:  
5/30/2024 3:45 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
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	0	0				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	0				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-0090

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

Worksheet A-7  
Part III  
Date/Time Prepared:  
5/30/2024 3:45 pm

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	1.000000	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0.000000	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	7,184,846	672,250	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	3,799,560	537,240	2.00
3.00	Total (sum of lines 1-2)	0	0	0	10,984,406	1,209,490	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	-25,974	747,004	0	0	8,578,126	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	207,648	0	0	4,544,448	2.00
3.00	Total (sum of lines 1-2)	-25,974	954,652	0	0	13,122,574	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 15-0090

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

Worksheet A-8

Date/Time Prepared:  
5/30/2024 3:45 pm

Line #	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.		
				Cost Center	Line #			
				3.00	4.00			
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)	B		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)	B		0	CENTRAL SERVICES & SUPPLY	14.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)			0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)			0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)			0		0.00	0	7.00
8.00	Television and radio service (chapter 21)			0		0.00	0	8.00
9.00	Parking lot (chapter 21)			0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-15,873,163	0		0.00	0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)			0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	4,381,082	0		0.00	0	12.00
13.00	Laundry and linen service			0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-429,282	0	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others			0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients			0		0.00	0	16.00
17.00	Sale of drugs to other than patients			0		0.00	0	17.00
18.00	Sale of medical records and abstracts			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	B	-20,244	0	CAFETERIA	11.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)			0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments			0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)			0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT			0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP			0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist			0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant			0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)			0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest			0		0.00	0	32.00
33.00	RENTAL INCOME	B	-119,069	0	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	33.00
33.01	RENTAL INCOME	B	-953,969	0	OPERATION OF PLANT	7.00	0	33.01

ADJUSTMENTS TO EXPENSES

Provider CCN: 15-0090

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

Worksheet A-8

Date/Time Prepared:  
5/30/2024 3:45 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			Wkst. A-7 Ref.
			Cost Center		Line #	
			1.00	2.00	3.00	
34.00	PROPERTY TAX ADJUSTMENT	B	-123,692	OTHER ADMINISTRATIVE AND GENERAL	5.04	0 34.00
34.01	PROPERTY TAX ADJUSTMENT	B	-4,031	PHARMACY	15.00	0 34.01
34.02	PROPERTY TAX ADJUSTMENT	B	-1,753	OPERATING ROOM	50.00	0 34.02
34.03	PROPERTY TAX ADJUSTMENT	B	-2,476	ADULTS & PEDIATRICS	30.00	0 34.03
35.00	PHYSICIAN RECRUITMENT	A	-350	DIETARY	10.00	0 35.00
35.01	PHYSICIAN RECRUITMENT	A	-350	EMERGENCY	91.00	0 35.01
35.02	PHYSICIAN RECRUITMENT	A	-1,666	PHARMACY	15.00	0 35.02
35.03	NRCC PHYSICIANS	A	-131,200	PHYSICIANS' PRIVATE OFFICES	192.00	0 35.03
36.00	FALL OUT ACCOUNTS	A	-11,839	OTHER ADMINISTRATIVE AND GENERAL	5.04	0 36.00
37.00	ADVERTISING EXPENSE	A	-318	EMPLOYEE BENEFITS DEPARTMENT	4.00	0 37.00
37.01	ADVERTISING EXPENSE	A	-10,110	OTHER ADMINISTRATIVE AND GENERAL	5.04	0 37.01
37.02	ADVERTISING EXPENSE	A	-3,848	MAINTENANCE & REPAIRS	6.00	0 37.02
37.03	ADVERTISING EXPENSE	A	493	OPERATION OF PLANT	7.00	0 37.03
37.04	ADVERTISING EXPENSE	A	-242	ADULTS & PEDIATRICS	30.00	0 37.04
37.05	ADVERTISING EXPENSE	A	-213	NEONATAL INTENSIVE CARE UNIT	35.00	0 37.05
37.06	ADVERTISING EXPENSE	A	-40	RECOVERY ROOM	51.00	0 37.06
37.07	ADVERTISING EXPENSE	A	-4	LABORATORY	60.00	0 37.07
37.08	ADVERTISING EXPENSE	A	-5	ULTRA SOUND	76.00	0 37.08
38.00	OUTSOURCED STAFF	B	-581	OTHER ADMINISTRATIVE AND GENERAL	5.04	0 38.00
38.01	OUTSOURCED STAFF	B	-101,223	EMERGENCY	91.00	0 38.01
39.00	GIFTS/DONATIONS	A	0		0.00	0 39.00
40.00	NON PATIENT BILLING	B	111,411	EMERGENCY	91.00	0 40.00
41.00	340B PRESCRIPTION DRUG PROGRAM	B	-24,848	PHARMACY	15.00	0 41.00
42.00	HAF FEES	A	-6,711,489	OTHER ADMINISTRATIVE AND GENERAL	5.04	0 42.00
43.00	UNECESSARY BORROWING	A	0		0.00	0 43.00
44.00	LOBBYING EXPENSE	A	-5,753	OTHER ADMINISTRATIVE AND GENERAL	5.04	0 44.00
45.00	PENSION ADJUSTMENT	A	1,591,415	EMPLOYEE BENEFITS DEPARTMENT	4.00	0 45.00
46.00	DISCOUNTS EARNED/REBATES	B	-850,022	OTHER ADMINISTRATIVE AND GENERAL	5.04	0 46.00
47.00	OTHER OPERATING REVENUE	B	-272	EMPLOYEE BENEFITS DEPARTMENT	4.00	0 47.00
47.01	OTHER OPERATING REVENUE	B	-421,003	OTHER ADMINISTRATIVE AND GENERAL	5.04	0 47.01
47.02	OTHER OPERATING REVENUE	B	44,826	OPERATION OF PLANT	7.00	0 47.02
47.03	OTHER OPERATING REVENUE	B	-2,899	ADULTS & PEDIATRICS	30.00	0 47.03
47.04	OTHER OPERATING REVENUE	B	0	SUBPROVIDER - IRF	41.00	0 47.04
47.05	OTHER OPERATING REVENUE	B	-51	RADIOLOGY-DIAGNOSTIC	54.00	0 47.05
47.06	OTHER ADJUSTMENTS (SPECIFY) (3)	B	0		0.00	0 47.06
48.00	PROGRAM FEES	B	-5,403	EMPLOYEE BENEFITS DEPARTMENT	4.00	0 48.00
48.01	PROGRAM FEES	B	-6,865	OTHER ADMINISTRATIVE AND GENERAL	5.04	0 48.01
48.02	PROGRAM FEES	B	-9,550	LABORATORY	60.00	0 48.02
48.03	PROGRAM FEES	B	-44,361	BARIATRIC CLINIC	76.05	0 48.03
49.00	DUES/FEES/EDUCATION	B	-14,620	EMPLOYEE BENEFITS DEPARTMENT	4.00	0 49.00
49.01	DUES/FEES/EDUCATION	B	-31,251	OTHER ADMINISTRATIVE AND GENERAL	5.04	0 49.01
49.02	DUES/FEES/EDUCATION	B	-1,470	DIETARY	10.00	0 49.02
49.03	DUES/FEES/EDUCATION	B	-20	RADIOLOGY-DIAGNOSTIC	54.00	0 49.03
49.04	DUES/FEES/EDUCATION	B	-25,809	LABORATORY	60.00	0 49.04
49.05	DUES/FEES/EDUCATION	B	20	BARIATRIC CLINIC	76.05	0 49.05
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-19,815,792			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: 15-0090

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

Worksheet A-8-1

Date/Time Prepared: 5/30/2024 3:45 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 HOME OFFICE COSTS:					
1.00	1.00	CAP REL COSTS-BLDG & FIXT	1,498,189	0	1.00
2.00	5.04	OTHER ADMINISTRATIVE AND GEN	27,618,514	25,929,406	2.00
3.00	16.00	MEDICAL RECORDS & LIBRARY	858,423	0	3.00
4.00	15.00	PHARMACY	335,362	0	4.00
4.01	0.00		0	0	4.01
4.02	0.00		0	0	4.02
4.03	0.00		0	0	4.03
4.04	0.00		0	0	4.04
4.05	0.00		0	0	4.05
4.06	0.00		0	0	4.06
4.07	0.00		0	0	4.07
4.08	0.00		0	0	4.08
4.09	0.00		0	0	4.09
4.10	0.00		0	0	4.10
4.11	0.00		0	0	4.11
4.12	0.00		0	0	4.12
4.13	0.00		0	0	4.13
4.14	0.00		0	0	4.14
4.15	0.00		0	0	4.15
4.16	0.00		0	0	4.16
4.17	0.00		0	0	4.17
4.18	0.00		0	0	4.18
4.19	0.00		0	0	4.19
4.20	0.00		0	0	4.20
4.21	0.00		0	0	4.21
4.22	0.00		0	0	4.22
4.23	0.00		0	0	4.23
4.24	0.00		0	0	4.24
4.25	0.00		0	0	4.25
4.26	0.00		0	0	4.26
4.27	0.00		0	0	4.27
4.28	0.00		0	0	4.28
4.29	0.00		0	0	4.29
4.30	0.00		0	0	4.30
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.		30,310,488	25,929,406	5.00

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

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

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

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

6.00	B	FRANCISCAN ALLI	100.00	FRANCISCAN ALLI	100.00	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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS

Provider CCN: 15-0090

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

Worksheet A-8-1

Date/Time Prepared:  
5/30/2024 3:45 pm

Symbol (1)	Name	Percentage of Ownership	Related Organization(s) and/or Home Office	
			Name	Percentage of Ownership
1.00	2.00	3.00	4.00	5.00

(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: 15-0090

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

Worksheet A-8-1

Date/Time Prepared:  
5/30/2024 3:45 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.	
	6.00	7.00	
<b>A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:</b>			
1.00	1,498,189	9	1.00
2.00	1,689,108	0	2.00
3.00	858,423	0	3.00
4.00	335,362	0	4.00
4.01	0	0	4.01
4.02	0	0	4.02
4.03	0	0	4.03
4.04	0	0	4.04
4.05	0	0	4.05
4.06	0	0	4.06
4.07	0	0	4.07
4.08	0	0	4.08
4.09	0	0	4.09
4.10	0	0	4.10
4.11	0	0	4.11
4.12	0	0	4.12
4.13	0	0	4.13
4.14	0	0	4.14
4.15	0	0	4.15
4.16	0	0	4.16
4.17	0	0	4.17
4.18	0	0	4.18
4.19	0	0	4.19
4.20	0	0	4.20
4.21	0	0	4.21
4.22	0	0	4.22
4.23	0	0	4.23
4.24	0	0	4.24
4.25	0	0	4.25
4.26	0	0	4.26
4.27	0	0	4.27
4.28	0	0	4.28
4.29	0	0	4.29
4.30	0	0	4.30
5.00	4,381,082		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>B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:</b>		

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	HEALTHCARE SERV		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: 15-0090

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

Worksheet A-8-2

Date/Time Prepared:  
5/30/2024 3:45 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	5.04	AGGREGATE-OTHER ADMINISTRATIVE AND G	551,336	551,336	0	0	211,500	1.00
2.00	13.00	AGGREGATE-NURSING ADMINISTRATION	1,369,118	1,369,118	0	0	211,500	2.00
3.00	22.00	AGGREGATE-I&R SERVICES-OTHER PRGM CO	27,736	27,736	0	0	197,500	3.00
4.00	23.00	AGGREGATE-PARAMED ED PRGM - EMERGENC	1,250	1,250	0	0	197,500	4.00
5.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	6,619,212	6,619,212	0	0	197,500	5.00
6.00	35.00	AGGREGATE-NEONATAL INTENSIVE CARE UN	809,663	809,663	0	0	237,100	6.00
7.00	41.00	AGGREGATE-SUBPROVIDER - IRF	848,491	848,491	0	0	197,500	7.00
8.00	50.00	AGGREGATE-OPERATING ROOM	12,827	12,827	0	0	246,400	8.00
9.00	53.00	AGGREGATE-ANESTHESIOLOGY	3,935,238	3,935,238	0	0	239,400	9.00
10.00	60.00	AGGREGATE-LABORATORY	0	0	0	0	260,300	10.00
11.00	65.00	AGGREGATE-RESPIRATORY THERAPY	23,021	23,021	0	0	211,500	11.00
12.00	76.02	AGGREGATE-CATH LAB	1,000	1,000	0	0	211,500	12.00
13.00	76.03	AGGREGATE-ACTIVITY THERAPEUTIC	19,951	19,951	0	0	211,500	13.00
14.00	76.05	AGGREGATE-BARIATRIC CLINIC	903,159	903,159	0	0	211,500	14.00
15.00	76.12	AGGREGATE-ANTI COAGULATION CLINIC	19,273	19,273	0	0	260,300	15.00
16.00	91.00	AGGREGATE-EMERGENCY	731,888	731,888	0	0	211,500	16.00
200.00			15,873,163	15,873,163	0	0	3,514,000	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.04	AGGREGATE-OTHER ADMINISTRATIVE AND G	0	0	0	0	0	1.00
2.00	13.00	AGGREGATE-NURSING ADMINISTRATION	0	0	0	0	0	2.00
3.00	22.00	AGGREGATE-I&R SERVICES-OTHER PRGM CO	0	0	0	0	0	3.00
4.00	23.00	AGGREGATE-PARAMED ED PRGM - EMERGENC	0	0	0	0	0	4.00
5.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	0	0	0	0	0	5.00
6.00	35.00	AGGREGATE-NEONATAL INTENSIVE CARE UN	0	0	0	0	0	6.00
7.00	41.00	AGGREGATE-SUBPROVIDER - IRF	0	0	0	0	0	7.00
8.00	50.00	AGGREGATE-OPERATING ROOM	0	0	0	0	0	8.00
9.00	53.00	AGGREGATE-ANESTHESIOLOGY	0	0	0	0	0	9.00
10.00	60.00	AGGREGATE-LABORATORY	0	0	0	0	0	10.00
11.00	65.00	AGGREGATE-RESPIRATORY THERAPY	0	0	0	0	0	11.00
12.00	76.02	AGGREGATE-CATH LAB	0	0	0	0	0	12.00
13.00	76.03	AGGREGATE-ACTIVITY THERAPEUTIC	0	0	0	0	0	13.00
14.00	76.05	AGGREGATE-BARIATRIC CLINIC	0	0	0	0	0	14.00
15.00	76.12	AGGREGATE-ANTI COAGULATION CLINIC	0	0	0	0	0	15.00
16.00	91.00	AGGREGATE-EMERGENCY	0	0	0	0	0	16.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
	1.00	2.00	15.00	16.00	17.00	18.00	
1.00	5.04	AGGREGATE-OTHER ADMINISTRATIVE AND G	0	0	0	551,336	1.00
2.00	13.00	AGGREGATE-NURSING ADMINISTRATION	0	0	0	1,369,118	2.00
3.00	22.00	AGGREGATE-I&R SERVICES-OTHER PRGM CO	0	0	0	27,736	3.00
4.00	23.00	AGGREGATE-PARAMED ED PRGM - EMERGENC	0	0	0	1,250	4.00
5.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	0	0	0	6,619,212	5.00
6.00	35.00	AGGREGATE-NEONATAL INTENSIVE CARE UN	0	0	0	809,663	6.00
7.00	41.00	AGGREGATE-SUBPROVIDER - IRF	0	0	0	848,491	7.00
8.00	50.00	AGGREGATE-OPERATING ROOM	0	0	0	12,827	8.00
9.00	53.00	AGGREGATE-ANESTHESIOLOGY	0	0	0	3,935,238	9.00
10.00	60.00	AGGREGATE-LABORATORY	0	0	0	0	10.00
11.00	65.00	AGGREGATE-RESPIRATORY THERAPY	0	0	0	23,021	11.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 15-0090

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

Worksheet A-8-2

Date/Time Prepared:  
5/30/2024 3:45 pm

	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		
12.00	76.02	AGGREGATE-CATH LAB	0	0	0	1,000		12.00
13.00	76.03	AGGREGATE-ACTIVITY THERAPEUTIC	0	0	0	19,951		13.00
14.00	76.05	AGGREGATE-BARIATRIC CLINIC	0	0	0	903,159		14.00
15.00	76.12	AGGREGATE-ANTI COAGULATION CLINIC	0	0	0	19,273		15.00
16.00	91.00	AGGREGATE-EMERGENCY	0	0	0	731,888		16.00
200.00			0	0	0	15,873,163		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0090

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

Worksheet B  
Part I  
Date/Time Prepared:  
5/30/2024 3:45 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		BLDG & FIXT	MVBLE EQUIP			
		1.00	2.00			
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS-BLDG & FIXT	8,578,126	8,578,126			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	4,544,448		4,544,448		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	21,414,080	35,310	2,451	21,451,841	4.00
5.04 00593	OTHER ADMINISTRATIVE AND GENERAL	40,409,916	638,061	466,785	1,139,331	42,654,093 5.04
6.00 00600	MAINTENANCE & REPAIRS	6,765,405	1,291,060	150,243	577,483	8,784,191 6.00
7.00 00700	OPERATION OF PLANT	1,720,902	366,125	23,026	101,243	2,211,296 7.00
8.00 00800	LAUNDRY & LINEN SERVICE	642,351	0	0	0	642,351 8.00
9.00 00900	HOUSEKEEPING	2,392,102	97,933	8,136	555,205	3,053,376 9.00
10.00 01000	DIETARY	1,019,686	86,393	13,634	143,843	1,263,556 10.00
11.00 01100	CAFETERIA	868,883	124,719	0	185,709	1,179,311 11.00
13.00 01300	NURSING ADMINISTRATION	2,834,101	13,193	0	784,647	3,631,941 13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	801,920	111,235	133,566	131,541	1,178,262 14.00
15.00 01500	PHARMACY	2,612,522	58,280	14,138	615,539	3,300,479 15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	1,370,561	88,792	0	74,108	1,533,461 16.00
17.00 01700	SOCIAL SERVICE	0	0	0	0	0 17.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD	58,157	0	0	16,124	74,281 21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRV	107,048	0	0	17,119	124,167 22.00
23.00 02300	PARAMED ED PRGM - EMERGENCY MEDICINE	71,727	727	0	1,864	74,318 23.00
23.01 02301	PARAMED ED PRGM- LAB	270,499	31,275	458	26,068	328,300 23.01
23.02 02302	PARAMED ED PRGM- PHARMACY	220,033	3,816	0	58,568	282,417 23.02
23.03 02303	PARAMED ED PRGM- RADIOLOGY	0	0	0	0	0 23.03
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	19,276,965	1,441,420	318,472	5,590,183	26,627,040 30.00
31.00 03100	INTENSIVE CARE UNIT	2,753,211	180,473	85,240	620,289	3,639,213 31.00
32.00 03200	CORONARY CARE UNIT	0	0	0	0	0 32.00
33.00 03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0 33.00
35.00 02060	NEONATAL INTENSIVE CARE UNIT	502,726	9,686	10,252	202,625	725,289 35.00
41.00 04100	SUBPROVIDER - I&R	1,915,114	107,909	16,162	694,518	2,733,703 41.00
42.00 04200	SUBPROVIDER	0	0	0	0	0 42.00
43.00 04300	NURSERY	1,144,319	0	0	227,314	1,371,633 43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	3,232,957	299,631	979,932	331,449	4,843,969 50.00
50.01 05001	OUTPATIENT SURGERY	884,450	255,926	26,572	228,504	1,395,452 50.01
51.00 05100	RECOVERY ROOM	464,460	100,877	45,406	129,326	740,069 51.00
53.00 05300	ANESTHESIOLOGY	17,729	0	778	10,794	29,301 53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	2,619,545	428,021	1,113,311	539,686	4,700,563 54.00
54.01 05401	RADIOLOGY-SPECIAL PROCEDURES	1,371,896	28,022	84,249	355,876	1,840,043 54.01
55.00 05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0 55.00
56.00 05600	RADIOISOTOPE	373,248	89,610	94,641	92,022	649,521 56.00
60.00 06000	LABORATORY	7,304,794	94,262	37,088	0	7,436,144 60.00
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	394,878	51,447	0	0	446,325 63.00
65.00 06500	RESPIRATORY THERAPY	2,374,522	38,890	98,192	486,482	2,998,086 65.00
66.00 06600	PHYSICAL THERAPY	3,777,442	26,387	37,875	1,023,974	4,865,678 66.00
67.00 06700	OCCUPATIONAL THERAPY	571,301	10,104	0	159,392	740,797 67.00
68.00 06800	SPEECH PATHOLOGY	562,827	0	25,875	124,808	713,510 68.00
69.00 06900	ELECTROCARDIOLOGY	885,037	69,202	195,723	242,207	1,392,169 69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	239,242	95,625	4,012	66,355	405,234 70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	13,382,669	0	0	0	13,382,669 71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	3,546,940	0	0	0	3,546,940 72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	4,618,938	0	0	0	4,618,938 73.00
76.00 03630	ULTRA SOUND	596,447	41,597	93,708	163,116	894,868 76.00
76.01 03951	PAIN CLINIC	651,343	223,942	15,278	179,277	1,069,840 76.01
76.02 03952	CATH LAB	2,293,156	164,245	340,973	587,433	3,385,807 76.02
76.03 03953	ACTIVITY THERAPEUTIC	1,593,273	103,693	369	443,190	2,140,525 76.03
76.04 03954	WOUND CARE CENTER	569,608	115,651	5,922	157,175	848,356 76.04
76.05 03340	BARITRIC CLINIC	559,414	35,019	2,379	154,902	751,714 76.05
76.06 03030	HEALTHY LIVING CENTER	0	0	0	0	0 76.06
76.07 03950	CV RESOURCE CENTER	0	0	0	0	0 76.07
76.08 03955	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0 76.08
76.09 03956	LACTATION CLINIC	0	0	0	0	0 76.09
76.10 03957	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0 76.10
76.11 03958	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0 76.11
76.12 03959	ANTI COAGULATION CLINIC	581,314	7,996	0	167,107	756,417 76.12
77.00 07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0 77.00
78.00 07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0 78.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
91.00 09100	EMERGENCY	5,090,686	291,526	72,569	1,183,237	6,638,018 91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART					0 92.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0090

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

Worksheet B  
Part I  
Date/Time Prepared:  
5/30/2024 3:45 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		BLDG & FIXT	MVBLE EQUIP			
	0	1.00	2.00	4.00	4A	
<b>OTHER REIMBURSABLE COST CENTERS</b>						
101.00	10100 HOME HEALTH AGENCY	8,083,516	24,679	1,021	1,979,695	10,088,911
102.00	10200 OPIOID TREATMENT PROGRAM	0	0	0	0	0
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00	11300 INTEREST EXPENSE					
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	188,936,434	7,282,759	4,518,436	20,569,328	186,732,542
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	165,432	14,465	4,061	14,143	198,101
192.00	19200 PHYSICIANS' PRIVATE OFFICES	339,387	248,911	0	136,133	724,431
192.01	19201 WORKING WELL	0	0	0	0	0
192.02	19202 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0
192.03	19203 MISC	0	0	0	0	0
194.00	07950 RESIDENTIAL	2,786,758	550,760	21,951	731,957	4,091,426
194.01	07954 OTHER NONREIMBURSABLE COST CENTERS	40	0	0	0	40
194.02	07952 PSYCHIATRIC	0	481,231	0	0	481,231
194.03	07953 CENTER OF HOPE	1,370	0	0	280	1,650
200.00	Cross Foot Adjustments					0
201.00	Negative Cost Centers		0	0	0	0
202.00	TOTAL (sum lines 118 through 201)	192,229,421	8,578,126	4,544,448	21,451,841	192,229,421

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0090

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

Worksheet B  
Part I  
Date/Time Prepared:  
5/30/2024 3:45 pm

Cost Center Description		OTHER ADMINISTRATIVE AND GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
		5.04	6.00	7.00	8.00	9.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.04	00593	OTHER ADMINISTRATIVE AND GENERAL	42,654,093				5.04
6.00	00600	MAINTENANCE & REPAIRS	2,504,970	11,289,161			6.00
7.00	00700	OPERATION OF PLANT	630,591	624,953	3,466,840		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	183,178	0	0	825,529	8.00
9.00	00900	HOUSEKEEPING	870,725	167,165	54,344	0	9.00
10.00	01000	DIETARY	360,326	147,467	47,940	0	58,239
11.00	01100	CAFETERIA	336,302	212,888	69,208	0	84,076
13.00	01300	NURSING ADMINISTRATION	1,035,713	22,520	7,321	0	8,894
14.00	01400	CENTRAL SERVICES & SUPPLY	336,003	189,871	61,725	0	74,986
15.00	01500	PHARMACY	941,191	99,480	32,340	0	39,288
16.00	01600	MEDICAL RECORDS & LIBRARY	437,294	151,562	49,271	0	59,857
17.00	01700	SOCIAL SERVICE	0	0	0	0	0
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	21,183	0	0	0	0
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	35,408	0	0	0	0
23.00	02300	PARAMED ED PRGM - EMERGENCY MEDICINE	21,193	1,241	403	0	490
23.01	02301	PARAMED ED PRGM- LAB	93,621	53,385	17,355	0	21,083
23.02	02302	PARAMED ED PRGM- PHARMACY	80,536	6,514	2,118	0	2,573
23.03	02303	PARAMED ED PRGM- RADIOLOGY	0	0	0	0	0
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	7,593,173	2,460,413	799,863	628,689	971,696
31.00	03100	INTENSIVE CARE UNIT	1,037,787	308,056	100,146	63,541	121,661
32.00	03200	CORONARY CARE UNIT	0	0	0	0	0
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0
35.00	02060	NEONATAL INTENSIVE CARE UNIT	206,829	16,533	5,375	9,298	6,530
41.00	04100	SUBPROVIDER - IIRF	779,565	184,195	59,880	105,300	72,744
42.00	04200	SUBPROVIDER	0	0	0	0	0
43.00	04300	NURSERY	391,146	0	0	18,701	0
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	1,381,345	511,452	166,268	0	201,988
50.01	05001	OUTPATIENT SURGERY	397,938	436,849	142,016	0	172,525
51.00	05100	RECOVERY ROOM	211,044	172,190	55,977	0	68,003
53.00	05300	ANESTHESIOLOGY	8,356	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,340,450	730,605	237,513	0	288,539
54.01	05401	RADIOLOGY-SPECIAL PROCEDURES	524,721	47,832	15,550	0	18,890
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0
56.00	05600	RADIOISOTOPE	185,223	152,958	49,725	0	60,408
60.00	06000	LABORATORY	2,120,550	160,899	52,307	0	63,544
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	127,278	87,817	28,548	0	34,682
65.00	06500	RESPIRATORY THERAPY	854,958	66,382	21,580	0	26,216
66.00	06600	PHYSICAL THERAPY	1,387,536	45,041	14,642	0	17,788
67.00	06700	OCCUPATIONAL THERAPY	211,252	17,247	5,607	0	6,811
68.00	06800	SPEECH PATHOLOGY	203,470	0	0	0	0
69.00	06900	ELECTROCARDIOLOGY	397,002	118,123	38,401	0	46,650
70.00	07000	ELECTROENCEPHALOGRAPHY	115,560	163,225	53,063	0	64,463
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,816,309	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,011,474	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	1,317,173	0	0	0	0
76.00	03630	ULTRA SOUND	255,188	71,004	23,083	0	28,042
76.01	03951	PAIN CLINIC	305,084	382,255	124,268	0	150,964
76.02	03952	CATH LAB	965,524	280,355	91,141	0	110,721
76.03	03953	ACTIVITY THERAPEUTIC	610,409	176,998	57,540	0	69,902
76.04	03954	WOUND CARE CENTER	241,924	197,409	64,176	0	77,963
76.05	03340	BARITRIC CLINIC	214,365	59,775	19,432	0	23,607
76.06	03030	HEALTHY LIVING CENTER	0	0	0	0	0
76.07	03950	CV RESOURCE CENTER	0	0	0	0	0
76.08	03955	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0
76.09	03956	LACTATION CLINIC	0	0	0	0	0
76.10	03957	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0
76.11	03958	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0
76.12	03959	ANTI COAGULATION CLINIC	215,706	13,649	4,437	0	5,390
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0
<b>OUTPATIENT SERVICE COST CENTERS</b>							
91.00	09100	EMERGENCY	1,892,950	497,617	161,771	0	196,524
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					
<b>OTHER REIMBURSABLE COST CENTERS</b>							
101.00	10100	HOME HEALTH AGENCY	2,877,035	42,125	13,694	0	16,636
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0090

Period:  
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To 12/31/2023

Worksheet B  
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Cost Center Description		OTHER	MAINTENANCE &	OPERATION OF	LAUNDRY &	HOUSEKEEPING	
		ADMINISTRATIVE AND GENERAL	REPAIRS	PLANT	LINEN SERVICE		
		5.04	6.00	7.00	8.00	9.00	
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	41,086,558	9,078,050	2,748,028	825,529	3,272,373 118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	56,492	24,692	8,027	0	9,751 190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	206,585	424,876	138,123	0	167,797 192.00
192.01	19201	WORKING WELL	0	0	0	0	0 192.01
192.02	19202	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0 192.02
192.03	19203	MISC	0	0	0	0	0 192.03
194.00	07950	RESIDENTIAL	1,166,744	940,112	305,622	0	371,280 194.00
194.01	07954	OTHER NONREIMBURSABLE COST CENTERS	11	0	0	0	0 194.01
194.02	07952	PSYCHIATRIC	137,232	821,431	267,040	0	324,409 194.02
194.03	07953	CENTER OF HOPE	471	0	0	0	0 194.03
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers	0	0	0	0	0 201.00
202.00		TOTAL (sum lines 118 through 201)	42,654,093	11,289,161	3,466,840	825,529	4,145,610 202.00

COST ALLOCATION - GENERAL SERVICE COSTS			Provider CCN: 15-0090		Period: From 01/01/2023 To 12/31/2023		Worksheet B Part I Date/Time Prepared: 5/30/2024 3:45 pm	
Cost Center Description			DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.04	00593	OTHER ADMINISTRATIVE AND GENERAL						5.04
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	1,877,528					10.00
11.00	01100	CAFETERIA	0	1,881,785				11.00
13.00	01300	NURSING ADMINISTRATION	0	57,971	4,764,360			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	24,666	2,285	1,867,798		14.00
15.00	01500	PHARMACY	0	52,366	0	43,214	4,508,358	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	8,692	338	1,466	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	2,787	0	110	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	3,087	0	0	0	22.00
23.00	02300	PARAMED ED PRGM - EMERGENCY MEDICINE	0	42	0	541	0	23.00
23.01	02301	PARAMED ED PRGM- LAB	0	2,659	0	2,665	0	23.01
23.02	02302	PARAMED ED PRGM- PHARMACY	0	12,510	0	0	0	23.02
23.03	02303	PARAMED ED PRGM- RADIOLOGY	0	0	0	0	0	23.03
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	1,480,046	536,576	1,920,358	193,807	0	30.00
31.00	03100	INTENSIVE CARE UNIT	149,588	66,930	469,846	14,333	0	31.00
32.00	03200	CORONARY CARE UNIT	0	0	0	0	0	32.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	0	29,260	213,968	2,499	0	35.00
41.00	04100	SUBPROVIDER - IRF	247,894	66,876	266,720	16,440	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	0	38,196	93,916	344,929	0	50.00
50.01	05001	OUTPATIENT SURGERY	0	21,491	164,341	33,542	0	50.01
51.00	05100	RECOVERY ROOM	0	11,611	70,460	2,753	0	51.00
53.00	05300	ANESTHESIOLOGY	0	2,643	0	655	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	58,917	1,550	41,010	0	54.00
54.01	05401	RADIOLOGY-SPECIAL PROCEDURES	0	35,259	122,675	67,927	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	8,325	0	86	0	56.00
60.00	06000	LABORATORY	0	0	0	1,262	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	53,494	0	14,258	0	65.00
66.00	06600	PHYSICAL THERAPY	0	103,103	3,777	41,457	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	16,873	0	458	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	10,888	0	309,239	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	27,647	69,434	28,958	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	7,240	0	1,712	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	4,508,358	73.00
76.00	03630	ULTRA SOUND	0	17,557	851	37,699	0	76.00
76.01	03951	PAIN CLINIC	0	18,853	136,653	19,395	0	76.01
76.02	03952	CATH LAB	0	52,206	272,444	203,030	0	76.02
76.03	03953	ACTIVITY THERAPEUTIC	0	57,940	233	3,875	0	76.03
76.04	03954	WOUND CARE CENTER	0	18,000	91,386	7,423	0	76.04
76.05	03340	BARIATRIC CLINIC	0	23,731	83,587	10,544	0	76.05
76.06	03030	HEALTHY LIVING CENTER	0	0	0	0	0	76.06
76.07	03950	CV RESOURCE CENTER	0	0	0	0	0	76.07
76.08	03955	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.08
76.09	03956	LACTATION CLINIC	0	0	0	0	0	76.09
76.10	03957	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.10
76.11	03958	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.11
76.12	03959	ANTI COAGULATION CLINIC	0	15,834	0	4,087	0	76.12
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
91.00	09100	EMERGENCY	0	151,396	590,808	158,433	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
101.00	10100	HOME HEALTH AGENCY	0	92,285	104,443	104,764	0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00



COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description		DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY		
		10.00	11.00	13.00	14.00	15.00		
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)					1,877,528 1,707,911 4,680,073 1,712,571 4,508,358	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN					0 3,099 0 112,903 0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES					0 27,245 14,118 14,730 0	192.00
192.01	19201	WORKING WELL					0 0 0 0 0	192.01
192.02	19202	PHYSICIANS' PRIVATE OFFICES					0 0 0 0 0	192.02
192.03	19203	MISC					0 0 0 0 0	192.03
194.00	07950	RESIDENTIAL					0 143,502 70,169 27,594 0	194.00
194.01	07954	OTHER NONREIMBURSABLE COST CENTERS					0 0 0 0 0	194.01
194.02	07952	PSYCHIATRIC					0 0 0 0 0	194.02
194.03	07953	CENTER OF HOPE					0 28 0 0 0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers					0 0 0 0 0	201.00
202.00		TOTAL (sum lines 118 through 201)					1,877,528 1,881,785 4,764,360 1,867,798 4,508,358	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	INTERNS & RESIDENTS		PARAMED PRGM - EMERGENCY MEDICINE	
			SERVICES-SALARY & FRINGES	SERVICES-OTHER PRGM COSTS APPRV		
	16.00	17.00	21.00	22.00	23.00	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.04 00593 OTHER ADMINISTRATIVE AND GENERAL						5.04
6.00 00600 MAINTENANCE & REPAIRS						6.00
7.00 00700 OPERATION OF PLANT						7.00
8.00 00800 LAUNDRY & LINEN SERVICE						8.00
9.00 00900 HOUSEKEEPING						9.00
10.00 01000 DIETARY						10.00
11.00 01100 CAFETERIA						11.00
13.00 01300 NURSING ADMINISTRATION						13.00
14.00 01400 CENTRAL SERVICES & SUPPLY						14.00
15.00 01500 PHARMACY						15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	2,241,941					16.00
17.00 01700 SOCIAL SERVICE	0	0				17.00
21.00 02100 I&R SERVICES-SALARY & FRINGES APPRVD	0	0	98,361			21.00
22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	162,662		22.00
23.00 02300 PARAMED ED PRGM - EMERGENCY MEDICINE	0	0	0	0	98,228	23.00
23.01 02301 PARAMED ED PRGM- LAB	0	0	0	0	0	23.01
23.02 02302 PARAMED ED PRGM- PHARMACY	0	0	0	0	0	23.02
23.03 02303 PARAMED ED PRGM- RADIOLOGY	0	0	0	0	0	23.03
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000 ADULTS & PEDIATRICS	213,950	0	35,410	58,558	0	30.00
31.00 03100 INTENSIVE CARE UNIT	30,543	0	0	0	0	31.00
32.00 03200 CORONARY CARE UNIT	0	0	0	0	0	32.00
33.00 03300 BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
35.00 02060 NEONATAL INTENSIVE CARE UNIT	5,436	0	0	0	0	35.00
41.00 04100 SUBPROVIDER - I&R	22,174	0	0	0	0	41.00
42.00 04200 SUBPROVIDER	0	0	0	0	0	42.00
43.00 04300 NURSERY	3,235	0	0	0	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000 OPERATING ROOM	242,997	0	0	0	0	50.00
50.01 05001 OUTPATIENT SURGERY	11,153	0	0	0	0	50.01
51.00 05100 RECOVERY ROOM	47,486	0	0	0	0	51.00
53.00 05300 ANESTHESIOLOGY	54,237	0	0	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	259,700	0	0	0	0	54.00
54.01 05401 RADIOLOGY-SPECIAL PROCEDURES	37,433	0	0	0	0	54.01
55.00 05500 RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00 05600 RADIOISOTOPE	31,398	0	0	0	0	56.00
60.00 06000 LABORATORY	224,372	0	0	0	0	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	4,609	0	0	0	0	63.00
65.00 06500 RESPIRATORY THERAPY	40,272	0	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	76,614	0	0	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	32,806	0	0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	25,895	0	0	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	78,847	0	0	0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	16,376	0	0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	155,731	0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	53,104	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	116,602	0	0	0	0	73.00
76.00 03630 ULTRA SOUND	40,131	0	0	0	0	76.00
76.01 03951 PAIN CLINIC	28,668	0	0	0	0	76.01
76.02 03952 CATH LAB	144,518	0	0	0	0	76.02
76.03 03953 ACTIVITY THERAPEUTIC	9,167	0	0	0	0	76.03
76.04 03954 WOUND CARE CENTER	12,766	0	0	0	0	76.04
76.05 03340 BARIATRIC CLINIC	2,439	0	0	0	0	76.05
76.06 03030 HEALTHY LIVING CENTER	0	0	0	0	0	76.06
76.07 03950 CV RESOURCE CENTER	0	0	0	0	0	76.07
76.08 03955 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.08
76.09 03956 LACTATION CLINIC	0	0	0	0	0	76.09
76.10 03957 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.10
76.11 03958 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.11
76.12 03959 ANTI COAGULATION CLINIC	4,292	0	0	0	0	76.12
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77.00
78.00 07800 CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
91.00 09100 EMERGENCY	184,593	0	62,951	104,104	98,228	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	INTERNS & RESIDENTS		PARAMED PRGM - EMERGENCY MEDICINE	
			SERVICES-SALARY & FRINGES	SERVICES-OTHER PRGM COSTS APPRV		
	16.00	17.00	21.00	22.00	23.00	
<b>OTHER REIMBURSABLE COST CENTERS</b>						
101.00	10100 HOME HEALTH AGENCY	30,397	0	0	0	101.00
102.00	10200 OPIOID TREATMENT PROGRAM	0	0	0	0	102.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00	11300 INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	2,241,941	0	98,361	162,662	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
192.01	19201 WORKING WELL	0	0	0	0	192.01
192.02	19202 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.02
192.03	19203 MISC	0	0	0	0	192.03
194.00	07950 RESIDENTIAL	0	0	0	0	194.00
194.01	07954 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	194.01
194.02	07952 PSYCHIATRIC	0	0	0	0	194.02
194.03	07953 CENTER OF HOPE	0	0	0	0	194.03
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	2,241,941	0	98,361	162,662	202.00

COST ALLOCATION - GENERAL SERVICE COSTS				Provider CCN: 15-0090	Period: From 01/01/2023 To 12/31/2023	Worksheet B Part I Date/Time Prepared: 5/30/2024 3:45 pm		
Cost Center Description			PARAMED ED PRGM- LAB	PARAMED ED PRGM- PHARMACY	PARAMED ED PRGM- RADIOLOGY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			23.01	23.02	23.03	24.00	25.00	
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.04	00593	OTHER ADMINISTRATIVE AND GENERAL						5.04
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE						17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD						21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV						22.00
23.00	02300	PARAMED ED PRGM - EMERGENCY MEDICINE						23.00
23.01	02301	PARAMED ED PRGM- LAB	519,068					23.01
23.02	02302	PARAMED ED PRGM- PHARMACY		386,668				23.02
23.03	02303	PARAMED ED PRGM- RADIOLOGY			0			23.03
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	43,519,579	-93,968	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	6,001,644	0	31.00
32.00	03200	CORONARY CARE UNIT	0	0	0	0	0	32.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	0	0	0	1,221,017	0	35.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	4,555,491	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	0	1,784,715	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	0	0	0	7,825,060	0	50.00
50.01	05001	OUTPATIENT SURGERY	0	0	0	2,775,307	0	50.01
51.00	05100	RECOVERY ROOM	0	0	0	1,379,593	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	95,192	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	7,658,847	0	54.00
54.01	05401	RADIOLOGY-SPECIAL PROCEDURES	0	0	0	2,710,330	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	1,137,644	0	56.00
60.00	06000	LABORATORY	519,068	0	0	10,578,146	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	729,259	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	4,075,246	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	6,555,636	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,031,851	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	1,263,002	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	2,197,231	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	826,873	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	17,354,709	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	4,611,518	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	386,668	0	10,947,739	0	73.00
76.00	03630	ULTRA SOUND	0	0	0	1,368,423	0	76.00
76.01	03951	PAIN CLINIC	0	0	0	2,235,980	0	76.01
76.02	03952	CATH LAB	0	0	0	5,505,746	0	76.02
76.03	03953	ACTIVITY THERAPEUTIC	0	0	0	3,126,589	0	76.03
76.04	03954	WOUND CARE CENTER	0	0	0	1,559,403	0	76.04
76.05	03340	BARITRIC CLINIC	0	0	0	1,189,194	0	76.05
76.06	03030	HEALTHY LIVING CENTER	0	0	0	0	0	76.06
76.07	03950	CV RESOURCE CENTER	0	0	0	0	0	76.07
76.08	03955	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.08
76.09	03956	LACTATION CLINIC	0	0	0	0	0	76.09
76.10	03957	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.10
76.11	03958	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.11
76.12	03959	ANTI COAGULATION CLINIC	0	0	0	1,019,812	0	76.12
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
91.00	09100	EMERGENCY	0	0	0	10,737,393	-167,055	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
101.00	10100	HOME HEALTH AGENCY	0	0	0	13,370,290	0	101.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0090

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

Worksheet B  
Part I  
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Cost Center Description			PARAMED ED PRGM- LAB	PARAMED ED PRGM- PHARMACY	PARAMED ED PRGM- RADIOLOGY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			23.01	23.02	23.03	24.00	25.00	
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	519,068	386,668	0	180,948,459	-261,023	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	413,065	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	1,717,905	0	192.00
192.01	19201	WORKING WELL	0	0	0	0	0	192.01
192.02	19202	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.02
192.03	19203	MISC	0	0	0	0	0	192.03
194.00	07950	RESIDENTIAL	0	0	0	7,116,449	0	194.00
194.01	07954	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	51	0	194.01
194.02	07952	PSYCHIATRIC	0	0	0	2,031,343	0	194.02
194.03	07953	CENTER OF HOPE	0	0	0	2,149	0	194.03
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	519,068	386,668	0	192,229,421	-261,023	202.00

COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 15-0090	Period: From 01/01/2023 To 12/31/2023	Worksheet B Part I Date/Time Prepared: 5/30/2024 3:45 pm
Cost Center Description		Total		
		26.00		
<b>GENERAL SERVICE COST CENTERS</b>				
1.00	00100	CAP REL COSTS-BLDG & FIXT		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT		4.00
5.04	00593	OTHER ADMINISTRATIVE AND GENERAL		5.04
6.00	00600	MAINTENANCE & REPAIRS		6.00
7.00	00700	OPERATION OF PLANT		7.00
8.00	00800	LAUNDRY & LINEN SERVICE		8.00
9.00	00900	HOUSEKEEPING		9.00
10.00	01000	DIETARY		10.00
11.00	01100	CAFETERIA		11.00
13.00	01300	NURSING ADMINISTRATION		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY		14.00
15.00	01500	PHARMACY		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY		16.00
17.00	01700	SOCIAL SERVICE		17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD		21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV		22.00
23.00	02300	PARAMED ED PRGM - EMERGENCY MEDICINE		23.00
23.01	02301	PARAMED ED PRGM- LAB		23.01
23.02	02302	PARAMED ED PRGM- PHARMACY		23.02
23.03	02303	PARAMED ED PRGM- RADIOLOGY		23.03
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	03000	ADULTS & PEDIATRICS	43,425,611	30.00
31.00	03100	INTENSIVE CARE UNIT	6,001,644	31.00
32.00	03200	CORONARY CARE UNIT	0	32.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	33.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	1,221,017	35.00
41.00	04100	SUBPROVIDER - IRF	4,555,491	41.00
42.00	04200	SUBPROVIDER	0	42.00
43.00	04300	NURSERY	1,784,715	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000	OPERATING ROOM	7,825,060	50.00
50.01	05001	OUTPATIENT SURGERY	2,775,307	50.01
51.00	05100	RECOVERY ROOM	1,379,593	51.00
53.00	05300	ANESTHESIOLOGY	95,192	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,658,847	54.00
54.01	05401	RADIOLOGY-SPECIAL PROCEDURES	2,710,330	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	55.00
56.00	05600	RADIOISOTOPE	1,137,644	56.00
60.00	06000	LABORATORY	10,578,146	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	729,259	63.00
65.00	06500	RESPIRATORY THERAPY	4,075,246	65.00
66.00	06600	PHYSICAL THERAPY	6,555,636	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,031,851	67.00
68.00	06800	SPEECH PATHOLOGY	1,263,002	68.00
69.00	06900	ELECTROCARDIOLOGY	2,197,231	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	826,873	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	17,354,709	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,611,518	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	10,947,739	73.00
76.00	03630	ULTRA SOUND	1,368,423	76.00
76.01	03951	PAIN CLINIC	2,235,980	76.01
76.02	03952	CATH LAB	5,505,746	76.02
76.03	03953	ACTIVITY THERAPEUTIC	3,126,589	76.03
76.04	03954	WOUND CARE CENTER	1,559,403	76.04
76.05	03340	BARITRIC CLINIC	1,189,194	76.05
76.06	03030	HEALTHY LIVING CENTER	0	76.06
76.07	03950	CV RESOURCE CENTER	0	76.07
76.08	03955	OTHER ANCILLARY SERVICE COST CENTERS	0	76.08
76.09	03956	LACTATION CLINIC	0	76.09
76.10	03957	OTHER ANCILLARY SERVICE COST CENTERS	0	76.10
76.11	03958	OTHER ANCILLARY SERVICE COST CENTERS	0	76.11
76.12	03959	ANTI COAGULATION CLINIC	1,019,812	76.12
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	78.00
<b>OUTPATIENT SERVICE COST CENTERS</b>				
91.00	09100	EMERGENCY	10,570,338	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>				
101.00	10100	HOME HEALTH AGENCY	13,370,290	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	102.00
<b>SPECIAL PURPOSE COST CENTERS</b>				
113.00	11300	INTEREST EXPENSE		113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	180,687,436	118.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0090

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

Worksheet B  
Part I  
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5/30/2024 3:45 pm

Cost Center Description		Total	
		26.00	
<b>NONREIMBURSABLE COST CENTERS</b>			
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	413,065	190.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	1,717,905	192.00
192.01	19201 WORKING WELL	0	192.01
192.02	19202 PHYSICIANS' PRIVATE OFFICES	0	192.02
192.03	19203 MISC	0	192.03
194.00	07950 RESIDENTIAL	7,116,449	194.00
194.01	07954 OTHER NONREIMBURSABLE COST CENTERS	51	194.01
194.02	07952 PSYCHIATRIC	2,031,343	194.02
194.03	07953 CENTER OF HOPE	2,149	194.03
200.00	Cross Foot Adjustments	0	200.00
201.00	Negative Cost Centers	0	201.00
202.00	TOTAL (sum lines 118 through 201)	191,968,398	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-0090	Period: From 01/01/2023 To 12/31/2023	Worksheet B Part II Date/Time Prepared: 5/30/2024 3: 45 pm
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Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		BLDG & FIXT	MVBLE EQUIP			
		0	1.00			
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	35,310	2,451	37,761	4.00
5.04 00593	OTHER ADMINISTRATIVE AND GENERAL	0	638,061	466,785	1,104,846	5.04
6.00 00600	MAINTENANCE & REPAIRS	0	1,291,060	150,243	1,441,303	6.00
7.00 00700	OPERATION OF PLANT	0	366,125	23,026	389,151	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	0	0	0	8.00
9.00 00900	HOUSEKEEPING	0	97,933	8,136	106,069	9.00
10.00 01000	DIETARY	0	86,393	13,634	100,027	10.00
11.00 01100	CAFETERIA	0	124,719	0	124,719	11.00
13.00 01300	NURSING ADMINISTRATION	0	13,193	0	13,193	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	111,235	133,566	244,801	14.00
15.00 01500	PHARMACY	0	58,280	14,138	72,418	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	88,792	0	88,792	16.00
17.00 01700	SOCIAL SERVICE	0	0	0	0	17.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	22.00
23.00 02300	PARAMED ED PRGM - EMERGENCY MEDICINE	0	727	0	727	23.00
23.01 02301	PARAMED ED PRGM- LAB	0	31,275	458	31,733	23.01
23.02 02302	PARAMED ED PRGM- PHARMACY	0	3,816	0	3,816	23.02
23.03 02303	PARAMED ED PRGM- RADIOLOGY	0	0	0	0	23.03
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	0	1,441,420	318,472	1,759,892	30.00
31.00 03100	INTENSIVE CARE UNIT	0	180,473	85,240	265,713	31.00
32.00 03200	CORONARY CARE UNIT	0	0	0	0	32.00
33.00 03300	BURN INTENSIVE CARE UNIT	0	0	0	0	33.00
35.00 02060	NEONATAL INTENSIVE CARE UNIT	0	9,686	10,252	19,938	35.00
41.00 04100	SUBPROVIDER - I&R	0	107,909	16,162	124,071	41.00
42.00 04200	SUBPROVIDER	0	0	0	0	42.00
43.00 04300	NURSERY	0	0	0	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	0	299,631	979,932	1,279,563	50.00
50.01 05001	OUTPATIENT SURGERY	0	255,926	26,572	282,498	50.01
51.00 05100	RECOVERY ROOM	0	100,877	45,406	146,283	51.00
53.00 05300	ANESTHESIOLOGY	0	0	778	778	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	428,021	1,113,311	1,541,332	54.00
54.01 05401	RADIOLOGY-SPECIAL PROCEDURES	0	28,022	84,249	112,271	54.01
55.00 05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	55.00
56.00 05600	RADIOISOTOPE	0	89,610	94,641	184,251	56.00
60.00 06000	LABORATORY	0	94,262	37,088	131,350	60.00
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	0	51,447	0	51,447	63.00
65.00 06500	RESPIRATORY THERAPY	0	38,890	98,192	137,082	65.00
66.00 06600	PHYSICAL THERAPY	0	26,387	37,875	64,262	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	10,104	0	10,104	67.00
68.00 06800	SPEECH PATHOLOGY	0	0	25,875	25,875	68.00
69.00 06900	ELECTROCARDIOLOGY	0	69,202	195,723	264,925	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	95,625	4,012	99,637	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.00 03630	ULTRA SOUND	0	41,597	93,708	135,305	76.00
76.01 03951	PAIN CLINIC	0	223,942	15,278	239,220	76.01
76.02 03952	CATH LAB	0	164,245	340,973	505,218	76.02
76.03 03953	ACTIVITY THERAPEUTIC	0	103,693	369	104,062	76.03
76.04 03954	WOUND CARE CENTER	0	115,651	5,922	121,573	76.04
76.05 03340	BARITRIC CLINIC	0	35,019	2,379	37,398	76.05
76.06 03030	HEALTHY LIVING CENTER	0	0	0	0	76.06
76.07 03950	CV RESOURCE CENTER	0	0	0	0	76.07
76.08 03955	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	76.08
76.09 03956	LACTATION CLINIC	0	0	0	0	76.09
76.10 03957	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	76.10
76.11 03958	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	76.11
76.12 03959	ANTI COAGULATION CLINIC	0	7,996	0	7,996	76.12
77.00 07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	77.00
78.00 07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	78.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
91.00 09100	EMERGENCY	0	291,526	72,569	364,095	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART				0	92.00



ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0090

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

Worksheet B  
Part II  
Date/Time Prepared:  
5/30/2024 3:45 pm

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT			
		BLDG & FIXT	MVBLE EQUIP					
		0	1.00				2.00	2A
<b>OTHER REIMBURSABLE COST CENTERS</b>								
101.00	10100	HOME HEALTH AGENCY	0	24,679	1,021	25,700	3,486	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	7,282,759	4,518,436	11,801,195	36,207	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	14,465	4,061	18,526	25	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	248,911	0	248,911	240	192.00
192.01	19201	WORKING WELL	0	0	0	0	0	192.01
192.02	19202	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.02
192.03	19203	MISC	0	0	0	0	0	192.03
194.00	07950	RESIDENTIAL	0	550,760	21,951	572,711	1,289	194.00
194.01	07954	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.01
194.02	07952	PSYCHIATRIC	0	481,231	0	481,231	0	194.02
194.03	07953	CENTER OF HOPE	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	8,578,126	4,544,448	13,122,574	37,761	202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 15-0090		Period: From 01/01/2023 To 12/31/2023		Worksheet B Part II Date/Time Prepared: 5/30/2024 3:45 pm	
Cost Center Description			OTHER ADMINI STRATI VE AND GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.04	6.00	7.00	8.00	9.00	
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.04	00593	OTHER ADMINI STRATI VE AND GENERAL	1,106,852					5.04
6.00	00600	MAINTENANCE & REPAIRS	65,003	1,507,323				6.00
7.00	00700	OPERATION OF PLANT	16,364	83,443	489,136			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	4,753	0	0	4,753		8.00
9.00	00900	HOUSEKEEPING	22,595	22,320	7,667	0	159,629	9.00
10.00	01000	DIETARY	9,350	19,690	6,764	0	2,243	10.00
11.00	01100	CAFETERIA	8,727	28,425	9,765	0	3,237	11.00
13.00	01300	NURSING ADMINISTRATION	26,876	3,007	1,033	0	342	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	8,719	25,351	8,709	0	2,887	14.00
15.00	01500	PHARMACY	24,424	13,283	4,563	0	1,513	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	11,348	20,236	6,952	0	2,305	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	550	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	919	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM - EMERGENCY MEDICINE	550	166	57	0	19	23.00
23.01	02301	PARAMED ED PRGM- LAB	2,429	7,128	2,449	0	812	23.01
23.02	02302	PARAMED ED PRGM- PHARMACY	2,090	870	299	0	99	23.02
23.03	02303	PARAMED ED PRGM- RADIOLOGY	0	0	0	0	0	23.03
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	197,036	328,512	112,848	3,619	37,417	30.00
31.00	03100	INTENSIVE CARE UNIT	26,930	41,131	14,130	366	4,685	31.00
32.00	03200	CORONARY CARE UNIT	0	0	0	0	0	32.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	5,367	2,208	758	54	251	35.00
41.00	04100	SUBPROVIDER - I RF	20,229	24,594	8,448	606	2,801	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	10,150	0	0	108	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	35,845	68,289	23,459	0	7,778	50.00
50.01	05001	OUTPATIENT SURGERY	10,326	58,328	20,037	0	6,643	50.01
51.00	05100	RECOVERY ROOM	5,477	22,991	7,898	0	2,619	51.00
53.00	05300	ANESTHESIOLOGY	217	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	34,784	97,550	33,511	0	11,110	54.00
54.01	05401	RADIOLOGY-SPECIAL PROCEDURES	13,616	6,387	2,194	0	727	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	4,806	20,423	7,016	0	2,326	56.00
60.00	06000	LABORATORY	55,027	21,483	7,380	0	2,447	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	3,303	11,725	4,028	0	1,335	63.00
65.00	06500	RESPIRATORY THERAPY	22,186	8,863	3,045	0	1,009	65.00
66.00	06600	PHYSICAL THERAPY	36,006	6,014	2,066	0	685	66.00
67.00	06700	OCCUPATIONAL THERAPY	5,482	2,303	791	0	262	67.00
68.00	06800	SPEECH PATHOLOGY	5,280	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	10,302	15,772	5,418	0	1,796	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	2,999	21,794	7,487	0	2,482	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	99,032	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	26,247	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	34,180	0	0	0	0	73.00
76.00	03630	ULTRA SOUND	6,622	9,480	3,257	0	1,080	76.00
76.01	03951	PAIN CLINIC	7,917	51,038	17,533	0	5,813	76.01
76.02	03952	CATH LAB	25,055	37,433	12,859	0	4,263	76.02
76.03	03953	ACTIVITY THERAPEUTIC	15,840	23,633	8,118	0	2,692	76.03
76.04	03954	WOUND CARE CENTER	6,278	26,358	9,055	0	3,002	76.04
76.05	03340	BARIATRIC CLINIC	5,563	7,981	2,742	0	909	76.05
76.06	03030	HEALTHY LIVING CENTER	0	0	0	0	0	76.06
76.07	03950	CV RESOURCE CENTER	0	0	0	0	0	76.07
76.08	03955	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.08
76.09	03956	LACTATION CLINIC	0	0	0	0	0	76.09
76.10	03957	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.10
76.11	03958	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.11
76.12	03959	ANTI COAGULATION CLINIC	5,597	1,822	626	0	208	76.12
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
91.00	09100	EMERGENCY	49,121	66,442	22,824	0	7,567	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
101.00	10100	HOME HEALTH AGENCY	74,658	5,624	1,932	0	641	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0090

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

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Cost Center Description		OTHER	MAINTENANCE &	OPERATION OF	LAUNDRY &	HOUSEKEEPING	
		ADMINISTRATIVE AND GENERAL	REPAIRS	PLANT	LINEN SERVICE		
		5.04	6.00	7.00	8.00	9.00	
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,066,175	1,212,097	387,718	4,753	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,466	3,297	1,133	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	5,361	56,729	19,488	0	192.00
192.01	19201	WORKING WELL	0	0	0	0	192.01
192.02	19202	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.02
192.03	19203	MISC	0	0	0	0	192.03
194.00	07950	RESIDENTIAL	30,277	125,523	43,120	0	194.00
194.01	07954	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	194.01
194.02	07952	PSYCHIATRIC	3,561	109,677	37,677	0	194.02
194.03	07953	CENTER OF HOPE	12	0	0	0	194.03
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,106,852	1,507,323	489,136	4,753	202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 15-0090		Period: From 01/01/2023 To 12/31/2023		Worksheet B Part II Date/Time Prepared: 5/30/2024 3:45 pm	
Cost Center Description			DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.04	00593	OTHER ADMINISTRATIVE AND GENERAL						5.04
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	138,327					10.00
11.00	01100	CAFETERIA	0	175,200				11.00
13.00	01300	NURSING ADMINISTRATION	0	5,397	51,230			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	2,296	25	293,020		14.00
15.00	01500	PHARMACY	0	4,875	0	6,779	128,939	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	809	4	230	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	259	0	17	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	287	0	0	0	22.00
23.00	02300	PARAMED ED PRGM - EMERGENCY MEDICINE	0	4	0	85	0	23.00
23.01	02301	PARAMED ED PRGM- LAB	0	248	0	418	0	23.01
23.02	02302	PARAMED ED PRGM- PHARMACY	0	1,165	0	0	0	23.02
23.03	02303	PARAMED ED PRGM- RADIOLOGY	0	0	0	0	0	23.03
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	109,042	49,960	20,645	30,404	0	30.00
31.00	03100	INTENSIVE CARE UNIT	11,021	6,231	5,052	2,249	0	31.00
32.00	03200	CORONARY CARE UNIT	0	0	0	0	0	32.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	0	2,724	2,301	392	0	35.00
41.00	04100	SUBPROVIDER - IRF	18,264	6,226	2,868	2,579	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	0	3,556	1,010	54,113	0	50.00
50.01	05001	OUTPATIENT SURGERY	0	2,001	1,767	5,262	0	50.01
51.00	05100	RECOVERY ROOM	0	1,081	758	432	0	51.00
53.00	05300	ANESTHESIOLOGY	0	246	0	103	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	5,485	17	6,434	0	54.00
54.01	05401	RADIOLOGY-SPECIAL PROCEDURES	0	3,283	1,319	10,656	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	775	0	13	0	56.00
60.00	06000	LABORATORY	0	0	0	198	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	4,980	0	2,237	0	65.00
66.00	06600	PHYSICAL THERAPY	0	9,599	41	6,504	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,571	0	72	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	1,014	0	48,513	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	2,574	747	4,543	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	674	0	269	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	128,939	73.00
76.00	03630	ULTRA SOUND	0	1,635	9	5,914	0	76.00
76.01	03951	PAIN CLINIC	0	1,755	1,469	3,043	0	76.01
76.02	03952	CATH LAB	0	4,861	2,930	31,851	0	76.02
76.03	03953	ACTIVITY THERAPEUTIC	0	5,394	3	608	0	76.03
76.04	03954	WOUND CARE CENTER	0	1,676	983	1,165	0	76.04
76.05	03340	BARIATRIC CLINIC	0	2,209	899	1,654	0	76.05
76.06	03030	HEALTHY LIVING CENTER	0	0	0	0	0	76.06
76.07	03950	CV RESOURCE CENTER	0	0	0	0	0	76.07
76.08	03955	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.08
76.09	03956	LACTATION CLINIC	0	0	0	0	0	76.09
76.10	03957	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.10
76.11	03958	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.11
76.12	03959	ANTI COAGULATION CLINIC	0	1,474	0	641	0	76.12
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
91.00	09100	EMERGENCY	0	14,095	6,353	24,855	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
101.00	10100	HOME HEALTH AGENCY	0	8,592	1,123	16,435	0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0090

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To 12/31/2023

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Cost Center Description		DI ETARY	CAFETERI A	NURSI NG ADM NI STRATION	CENTRAL SERVI CES & SUPPLY	PHARMACY	
		10.00	11.00	13.00	14.00	15.00	
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	138,327	159,011	50,323	268,668	128,939
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	288	0	17,712	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	2,537	152	2,311	0
192.01	19201	WORKING WELL	0	0	0	0	0
192.02	19202	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0
192.03	19203	MISC	0	0	0	0	0
194.00	07950	RESIDENTIAL	0	13,361	755	4,329	0
194.01	07954	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0
194.02	07952	PSYCHIATRIC	0	0	0	0	0
194.03	07953	CENTER OF HOPE	0	3	0	0	0
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118 through 201)	138,327	175,200	51,230	293,020	128,939

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 15-0090	Period: From 01/01/2023 To 12/31/2023	Worksheet B Part II Date/Time Prepared: 5/30/2024 3:45 pm		
Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	INTERNS & RESIDENTS		PARAMED PRGM - EMERGENCY MEDICINE		
	16.00	17.00	SERVICES-SALARY & FRINGES	SERVICES-OTHER PRGM COSTS APPRV			21.00
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.04	00593	OTHER ADMINISTRATIVE AND GENERAL					5.04
6.00	00600	MAINTENANCE & REPAIRS					6.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	130,806				16.00
17.00	01700	SOCIAL SERVICE	0	0			17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	854		21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0		1,236	22.00
23.00	02300	PARAMED PRGM - EMERGENCY MEDICINE	0	0			23.00
23.01	02301	PARAMED PRGM- LAB	0	0			23.01
23.02	02302	PARAMED PRGM- PHARMACY	0	0			23.02
23.03	02303	PARAMED PRGM- RADIOLOGY	0	0			23.03
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	12,517	0			30.00
31.00	03100	INTENSIVE CARE UNIT	1,787	0			31.00
32.00	03200	CORONARY CARE UNIT	0	0			32.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0			33.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	318	0			35.00
41.00	04100	SUBPROVIDER - IRF	1,297	0			41.00
42.00	04200	SUBPROVIDER	0	0			42.00
43.00	04300	NURSERY	189	0			43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	14,216	0			50.00
50.01	05001	OUTPATIENT SURGERY	652	0			50.01
51.00	05100	RECOVERY ROOM	2,778	0			51.00
53.00	05300	ANESTHESIOLOGY	3,173	0			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	14,838	0			54.00
54.01	05401	RADIOLOGY-SPECIAL PROCEDURES	2,190	0			54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0			55.00
56.00	05600	RADIOISOTOPE	1,837	0			56.00
60.00	06000	LABORATORY	13,127	0			60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	270	0			63.00
65.00	06500	RESPIRATORY THERAPY	2,356	0			65.00
66.00	06600	PHYSICAL THERAPY	4,482	0			66.00
67.00	06700	OCCUPATIONAL THERAPY	1,919	0			67.00
68.00	06800	SPEECH PATHOLOGY	1,515	0			68.00
69.00	06900	ELECTROCARDIOLOGY	4,613	0			69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	958	0			70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	9,111	0			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,107	0			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,822	0			73.00
76.00	03630	ULTRA SOUND	2,348	0			76.00
76.01	03951	PAIN CLINIC	1,677	0			76.01
76.02	03952	CATH LAB	8,455	0			76.02
76.03	03953	ACTIVITY THERAPEUTIC	536	0			76.03
76.04	03954	WOUND CARE CENTER	747	0			76.04
76.05	03340	BARIATRIC CLINIC	143	0			76.05
76.06	03030	HEALTHY LIVING CENTER	0	0			76.06
76.07	03950	CV RESOURCE CENTER	0	0			76.07
76.08	03955	OTHER ANCILLARY SERVICE COST CENTERS	0	0			76.08
76.09	03956	LACTATION CLINIC	0	0			76.09
76.10	03957	OTHER ANCILLARY SERVICE COST CENTERS	0	0			76.10
76.11	03958	OTHER ANCILLARY SERVICE COST CENTERS	0	0			76.11
76.12	03959	ANTI COAGULATION CLINIC	251	0			76.12
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0			77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0			78.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
91.00	09100	EMERGENCY	10,799	0			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0090

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Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	INTERNS & RESIDENTS		PARAMED PRGM - EMERGENCY MEDICINE	
			SERVICES-SALARY & FRINGES	SERVICES-OTHER PRGM COSTS APPRV		
			16.00	17.00		
<b>OTHER REIMBURSABLE COST CENTERS</b>						
101.00	10100 HOME HEALTH AGENCY	1,778	0			101.00
102.00	10200 OPIOID TREATMENT PROGRAM	0	0			102.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00	11300 INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	130,806	0	0	0	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0			190.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	0			192.00
192.01	19201 WORKING WELL	0	0			192.01
192.02	19202 PHYSICIANS' PRIVATE OFFICES	0	0			192.02
192.03	19203 MISC	0	0			192.03
194.00	07950 RESIDENTIAL	0	0			194.00
194.01	07954 OTHER NONREIMBURSABLE COST CENTERS	0	0			194.01
194.02	07952 PSYCHIATRIC	0	0			194.02
194.03	07953 CENTER OF HOPE	0	0			194.03
200.00	Cross Foot Adjustments			854	1,236	1,611
201.00	Negative Cost Centers	0	0	0	0	0
202.00	TOTAL (sum lines 118 through 201)	130,806	0	854	1,236	1,611

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 15-0090		Period: From 01/01/2023 To 12/31/2023		Worksheet B Part II Date/Time Prepared: 5/30/2024 3:45 pm	
Cost Center Description			PARAMED ED PRGM- LAB	PARAMED ED PRGM- PHARMACY	PARAMED ED PRGM- RADIOLOGY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			23.01	23.02	23.03	24.00	25.00	
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.04	00593	OTHER ADMINISTRATIVE AND GENERAL						5.04
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE						17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD						21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV						22.00
23.00	02300	PARAMED ED PRGM - EMERGENCY MEDICINE						23.00
23.01	02301	PARAMED ED PRGM- LAB	45,263					23.01
23.02	02302	PARAMED ED PRGM- PHARMACY		8,442				23.02
23.03	02303	PARAMED ED PRGM- RADIOLOGY			0			23.03
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS				2,671,724	0	30.00
31.00	03100	INTENSIVE CARE UNIT				380,387	0	31.00
32.00	03200	CORONARY CARE UNIT				0	0	32.00
33.00	03300	BURN INTENSIVE CARE UNIT				0	0	33.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT				34,668	0	35.00
41.00	04100	SUBPROVIDER - IRF				213,206	0	41.00
42.00	04200	SUBPROVIDER				0	0	42.00
43.00	04300	NURSERY				10,847	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM				1,488,413	0	50.00
50.01	05001	OUTPATIENT SURGERY				387,916	0	50.01
51.00	05100	RECOVERY ROOM				190,545	0	51.00
53.00	05300	ANESTHESIOLOGY				4,536	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC				1,746,011	0	54.00
54.01	05401	RADIOLOGY-SPECIAL PROCEDURES				153,270	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC				0	0	55.00
56.00	05600	RADIOISOTOPE				221,609	0	56.00
60.00	06000	LABORATORY				231,012	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.				72,108	0	63.00
65.00	06500	RESPIRATORY THERAPY				182,615	0	65.00
66.00	06600	PHYSICAL THERAPY				131,462	0	66.00
67.00	06700	OCCUPATIONAL THERAPY				22,785	0	67.00
68.00	06800	SPEECH PATHOLOGY				82,417	0	68.00
69.00	06900	ELECTROCARDIOLOGY				311,116	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY				136,417	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT				108,143	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS				29,354	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS				169,941	0	73.00
76.00	03630	ULTRA SOUND				165,937	0	76.00
76.01	03951	PAIN CLINIC				329,781	0	76.01
76.02	03952	CATH LAB				633,959	0	76.02
76.03	03953	ACTIVITY THERAPEUTIC				161,666	0	76.03
76.04	03954	WOUND CARE CENTER				171,114	0	76.04
76.05	03340	BARITRIC CLINIC				59,771	0	76.05
76.06	03030	HEALTHY LIVING CENTER				0	0	76.06
76.07	03950	CV RESOURCE CENTER				0	0	76.07
76.08	03955	OTHER ANCILLARY SERVICE COST CENTERS				0	0	76.08
76.09	03956	LACTATION CLINIC				0	0	76.09
76.10	03957	OTHER ANCILLARY SERVICE COST CENTERS				0	0	76.10
76.11	03958	OTHER ANCILLARY SERVICE COST CENTERS				0	0	76.11
76.12	03959	ANTI COAGULATION CLINIC				18,909	0	76.12
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION				0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY				0	0	78.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
91.00	09100	EMERGENCY				568,234	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
101.00	10100	HOME HEALTH AGENCY				139,969	0	101.00



ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 15-0090			Period: From 01/01/2023 To 12/31/2023		Worksheet B Part II Date/Time Prepared: 5/30/2024 3:45 pm	
Cost Center Description			PARAMED ED PRGM- LAB	PARAMED ED PRGM- PHARMACY	PARAMED ED PRGM- RADIOLOGY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments		
			23.01	23.02	23.03	24.00	25.00		
102.00	10200	OPIOID TREATMENT PROGRAM				0		0	102.00
SPECIAL PURPOSE COST CENTERS									
113.00	11300	INTEREST EXPENSE							113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	0	0	11,229,842		0	118.00
NONREIMBURSABLE COST CENTERS									
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN				42,822		0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES				342,190		0	192.00
192.01	19201	WORKING WELL				0		0	192.01
192.02	19202	PHYSICIANS' PRIVATE OFFICES				0		0	192.02
192.03	19203	MISC				0		0	192.03
194.00	07950	RESIDENTIAL				805,661		0	194.00
194.01	07954	OTHER NONREIMBURSABLE COST CENTERS				0		0	194.01
194.02	07952	PSYCHIATRIC				644,638		0	194.02
194.03	07953	CENTER OF HOPE				15		0	194.03
200.00		Cross Foot Adjustments	45,263	8,442	0	57,406		0	200.00
201.00		Negative Cost Centers	0	0	0	0		0	201.00
202.00		TOTAL (sum lines 118 through 201)	45,263	8,442	0	13,122,574		0	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-0090	Period: From 01/01/2023 To 12/31/2023	Worksheet B Part II Date/Time Prepared: 5/30/2024 3:45 pm
Cost Center Description		Total		
		26.00		
<b>GENERAL SERVICE COST CENTERS</b>				
1.00	00100	CAP REL COSTS-BLDG & FIXT		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT		4.00
5.04	00593	OTHER ADMINISTRATIVE AND GENERAL		5.04
6.00	00600	MAINTENANCE & REPAIRS		6.00
7.00	00700	OPERATION OF PLANT		7.00
8.00	00800	LAUNDRY & LINEN SERVICE		8.00
9.00	00900	HOUSEKEEPING		9.00
10.00	01000	DIETARY		10.00
11.00	01100	CAFETERIA		11.00
13.00	01300	NURSING ADMINISTRATION		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY		14.00
15.00	01500	PHARMACY		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY		16.00
17.00	01700	SOCIAL SERVICE		17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD		21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV		22.00
23.00	02300	PARAMED PRGM - EMERGENCY MEDICINE		23.00
23.01	02301	PARAMED PRGM- LAB		23.01
23.02	02302	PARAMED PRGM- PHARMACY		23.02
23.03	02303	PARAMED PRGM- RADIOLOGY		23.03
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	03000	ADULTS & PEDIATRICS	2,671,724	30.00
31.00	03100	INTENSIVE CARE UNIT	380,387	31.00
32.00	03200	CORONARY CARE UNIT	0	32.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	33.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	34,668	35.00
41.00	04100	SUBPROVIDER - I RF	213,206	41.00
42.00	04200	SUBPROVIDER	0	42.00
43.00	04300	NURSERY	10,847	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000	OPERATING ROOM	1,488,413	50.00
50.01	05001	OUTPATIENT SURGERY	387,916	50.01
51.00	05100	RECOVERY ROOM	190,545	51.00
53.00	05300	ANESTHESIOLOGY	4,536	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,746,011	54.00
54.01	05401	RADIOLOGY-SPECIAL PROCEDURES	153,270	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	55.00
56.00	05600	RADIOISOTOPE	221,609	56.00
60.00	06000	LABORATORY	231,012	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	72,108	63.00
65.00	06500	RESPIRATORY THERAPY	182,615	65.00
66.00	06600	PHYSICAL THERAPY	131,462	66.00
67.00	06700	OCCUPATIONAL THERAPY	22,785	67.00
68.00	06800	SPEECH PATHOLOGY	82,417	68.00
69.00	06900	ELECTROCARDIOLOGY	311,116	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	136,417	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	108,143	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	29,354	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	169,941	73.00
76.00	03630	ULTRA SOUND	165,937	76.00
76.01	03951	PAIN CLINIC	329,781	76.01
76.02	03952	CATH LAB	633,959	76.02
76.03	03953	ACTIVITY THERAPEUTIC	161,666	76.03
76.04	03954	WOUND CARE CENTER	171,114	76.04
76.05	03340	BARITRIC CLINIC	59,771	76.05
76.06	03030	HEALTHY LIVING CENTER	0	76.06
76.07	03950	CV RESOURCE CENTER	0	76.07
76.08	03955	OTHER ANCILLARY SERVICE COST CENTERS	0	76.08
76.09	03956	LACTATION CLINIC	0	76.09
76.10	03957	OTHER ANCILLARY SERVICE COST CENTERS	0	76.10
76.11	03958	OTHER ANCILLARY SERVICE COST CENTERS	0	76.11
76.12	03959	ANTI COAGULATION CLINIC	18,909	76.12
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	78.00
<b>OUTPATIENT SERVICE COST CENTERS</b>				
91.00	09100	EMERGENCY	568,234	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>				
101.00	10100	HOME HEALTH AGENCY	139,969	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	102.00
<b>SPECIAL PURPOSE COST CENTERS</b>				
113.00	11300	INTEREST EXPENSE		113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	11,229,842	118.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0090

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

Worksheet B  
Part II  
Date/Time Prepared:  
5/30/2024 3:45 pm

Cost Center Description		Total	
		26.00	
<b>NONREIMBURSABLE COST CENTERS</b>			
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	42,822	190.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	342,190	192.00
192.01	19201 WORKING WELL	0	192.01
192.02	19202 PHYSICIANS' PRIVATE OFFICES	0	192.02
192.03	19203 MISC	0	192.03
194.00	07950 RESIDENTIAL	805,661	194.00
194.01	07954 OTHER NONREIMBURSABLE COST CENTERS	0	194.01
194.02	07952 PSYCHIATRIC	644,638	194.02
194.03	07953 CENTER OF HOPE	15	194.03
200.00	Cross Foot Adjustments	57,406	200.00
201.00	Negative Cost Centers	0	201.00
202.00	TOTAL (sum lines 118 through 201)	13,122,574	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0090

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

Worksheet B-1

Date/Time Prepared:  
5/30/2024 3:45 pm

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES ADJ)	Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
	1.00	2.00				
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS-BLDG & FIXT	472,034				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		3,697,036			2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	1,943	1,994	76,612,471		4.00
5.04 00593	OTHER ADMINISTRATIVE AND GENERAL	35,111	379,743	4,068,967	-42,654,093	149,575,328
6.00 00600	MAINTENANCE & REPAIRS	71,044	122,227	2,062,403	0	8,784,191
7.00 00700	OPERATION OF PLANT	20,147	18,732	361,574	0	2,211,296
8.00 00800	LAUNDRY & LINEN SERVICE	0	0	0	0	642,351
9.00 00900	HOUSEKEEPING	5,389	6,619	1,982,841	0	3,053,376
10.00 01000	DIETARY	4,754	11,092	513,717	0	1,263,556
11.00 01100	CAFETERIA	6,863	0	663,234	0	1,179,311
13.00 01300	NURSING ADMINISTRATION	726	0	2,802,259	0	3,631,941
14.00 01400	CENTRAL SERVICES & SUPPLY	6,121	108,660	469,781	0	1,178,262
15.00 01500	PHARMACY	3,207	11,502	2,198,314	0	3,300,479
16.00 01600	MEDICAL RECORDS & LIBRARY	4,886	0	264,666	0	1,533,461
17.00 01700	SOCIAL SERVICE	0	0	0	0	0
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	57,586	0	74,281
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	61,138	0	124,167
23.00 02300	PARAMED ED PRGM - EMERGENCY MEDICINE	40	0	6,657	0	74,318
23.01 02301	PARAMED ED PRGM- LAB	1,721	373	93,100	0	328,300
23.02 02302	PARAMED ED PRGM- PHARMACY	210	0	209,166	0	282,417
23.03 02303	PARAMED ED PRGM- RADIOLOGY	0	0	0	0	0
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	79,318	259,086	19,964,704	0	26,627,040
31.00 03100	INTENSIVE CARE UNIT	9,931	69,345	2,215,277	0	3,639,213
32.00 03200	CORONARY CARE UNIT	0	0	0	0	0
33.00 03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0
35.00 02060	NEONATAL INTENSIVE CARE UNIT	533	8,340	723,648	0	725,289
41.00 04100	SUBPROVIDER - I&R	5,938	13,148	2,480,378	0	2,733,703
42.00 04200	SUBPROVIDER	0	0	0	0	0
43.00 04300	NURSERY	0	0	811,821	0	1,371,633
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	16,488	797,202	1,183,725	0	4,843,969
50.01 05001	OUTPATIENT SURGERY	14,083	21,617	816,070	0	1,395,452
51.00 05100	RECOVERY ROOM	5,551	36,939	461,869	0	740,069
53.00 05300	ANESTHESIOLOGY	0	633	38,551	0	29,301
54.00 05400	RADIOLOGY-DIAGNOSTIC	23,553	905,709	1,927,414	0	4,700,563
54.01 05401	RADIOLOGY-SPECIAL PROCEDURES	1,542	68,539	1,270,962	0	1,840,043
55.00 05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0
56.00 05600	RADIOISOTOPE	4,931	76,993	328,644	0	649,521
60.00 06000	LABORATORY	5,187	30,172	0	0	7,436,144
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	2,831	0	0	0	446,325
65.00 06500	RESPIRATORY THERAPY	2,140	79,882	1,737,405	0	2,998,086
66.00 06600	PHYSICAL THERAPY	1,452	30,812	3,656,986	0	4,865,678
67.00 06700	OCCUPATIONAL THERAPY	556	0	569,246	0	740,797
68.00 06800	SPEECH PATHOLOGY	0	21,050	445,734	0	713,510
69.00 06900	ELECTROCARDIOLOGY	3,808	159,226	865,010	0	1,392,169
70.00 07000	ELECTROENCEPHALOGRAPHY	5,262	3,264	236,979	0	405,234
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	13,382,669
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	3,546,940
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	4,618,938
76.00 03630	ULTRA SOUND	2,289	76,234	582,548	289	894,868
76.01 03951	PAIN CLINIC	12,323	12,429	640,263	0	1,069,840
76.02 03952	CATH LAB	9,038	277,391	2,097,939	0	3,385,807
76.03 03953	ACTIVITY THERAPEUTIC	5,706	300	1,582,792	0	2,140,525
76.04 03954	WOUND CARE CENTER	6,364	4,818	561,329	0	848,356
76.05 03340	BARITRIC CLINIC	1,927	1,935	553,213	0	751,714
76.06 03030	HEALTHY LIVING CENTER	0	0	0	0	0
76.07 03950	CV RESOURCE CENTER	0	0	0	0	0
76.08 03955	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0
76.09 03956	LACTATION CLINIC	0	0	0	0	0
76.10 03957	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0
76.11 03958	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0
76.12 03959	ANTI COAGULATION CLINIC	440	0	596,801	0	756,417
77.00 07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0
78.00 07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0
<b>OUTPATIENT SERVICE COST CENTERS</b>						
91.00 09100	EMERGENCY	16,042	59,037	4,225,771	0	6,638,018
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART					

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0090

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

Worksheet B-1

Date/Time Prepared:  
5/30/2024 3:45 pm

Cost Center Description	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES ADJ)	Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)		
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)						
	1.00	2.00	4.00					
<b>OTHER REIMBURSABLE COST CENTERS</b>								
101.00	10100	HOME HEALTH AGENCY	1,358	831	7,070,212	0	10,088,911	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	400,753	3,675,874	73,460,694	-42,654,093	144,078,449	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	796	3,304	50,509	0	198,101	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	13,697	0	486,181	0	724,431	192.00
192.01	19201	WORKING WELL	0	0	0	0	0	192.01
192.02	19202	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.02
192.03	19203	MISC	0	0	0	0	0	192.03
194.00	07950	RESIDENTIAL	30,307	17,858	2,614,086	0	4,091,426	194.00
194.01	07954	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	40	194.01
194.02	07952	PSYCHIATRIC	26,481	0	0	0	481,231	194.02
194.03	07953	CENTER OF HOPE	0	0	1,001	0	1,650	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	8,578,126	4,544,448	21,451,841		42,654,093	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	18.172687	1.229214	0.280005		0.285168	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			37,761		1,106,852	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000493		0.007400	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: 15-0090		Period: From 01/01/2023 To 12/31/2023		Worksheet B-1	
Date/Time Prepared: 5/30/2024 3:45 pm								
Cost Center Description			MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUND)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT MEALS)	
			6.00	7.00	8.00	9.00	10.00	
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.04	00593	OTHER ADMINISTRATIVE AND GENERAL						5.04
6.00	00600	MAINTENANCE & REPAIRS	363,936					6.00
7.00	00700	OPERATION OF PLANT	20,147	343,789				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	575,002			8.00
9.00	00900	HOUSEKEEPING	5,389	5,389	0	338,400		9.00
10.00	01000	DIETARY	4,754	4,754	0	4,754	199,277	10.00
11.00	01100	CAFETERIA	6,863	6,863	0	6,863	0	11.00
13.00	01300	NURSING ADMINISTRATION	726	726	0	726	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	6,121	6,121	0	6,121	0	14.00
15.00	01500	PHARMACY	3,207	3,207	0	3,207	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,886	4,886	0	4,886	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM - EMERGENCY MEDICINE	40	40	0	40	0	23.00
23.01	02301	PARAMED ED PRGM- LAB	1,721	1,721	0	1,721	0	23.01
23.02	02302	PARAMED ED PRGM- PHARMACY	210	210	0	210	0	23.02
23.03	02303	PARAMED ED PRGM- RADIOLOGY	0	0	0	0	0	23.03
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	79,318	79,318	437,898	79,318	157,089	30.00
31.00	03100	INTENSIVE CARE UNIT	9,931	9,931	44,258	9,931	15,877	31.00
32.00	03200	CORONARY CARE UNIT	0	0	0	0	0	32.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	533	533	6,476	533	0	35.00
41.00	04100	SUBPROVIDER - I&R	5,938	5,938	73,344	5,938	26,311	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	13,026	0	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	16,488	16,488	0	16,488	0	50.00
50.01	05001	OUTPATIENT SURGERY	14,083	14,083	0	14,083	0	50.01
51.00	05100	RECOVERY ROOM	5,551	5,551	0	5,551	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	23,553	23,553	0	23,553	0	54.00
54.01	05401	RADIOLOGY-SPECIAL PROCEDURES	1,542	1,542	0	1,542	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	4,931	4,931	0	4,931	0	56.00
60.00	06000	LABORATORY	5,187	5,187	0	5,187	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	2,831	2,831	0	2,831	0	63.00
65.00	06500	RESPIRATORY THERAPY	2,140	2,140	0	2,140	0	65.00
66.00	06600	PHYSICAL THERAPY	1,452	1,452	0	1,452	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	556	556	0	556	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	3,808	3,808	0	3,808	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	5,262	5,262	0	5,262	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03630	ULTRA SOUND	2,289	2,289	0	2,289	0	76.00
76.01	03951	PAIN CLINIC	12,323	12,323	0	12,323	0	76.01
76.02	03952	CATH LAB	9,038	9,038	0	9,038	0	76.02
76.03	03953	ACTIVITY THERAPEUTIC	5,706	5,706	0	5,706	0	76.03
76.04	03954	WOUND CARE CENTER	6,364	6,364	0	6,364	0	76.04
76.05	03340	BARIBATRIC CLINIC	1,927	1,927	0	1,927	0	76.05
76.06	03030	HEALTHY LIVING CENTER	0	0	0	0	0	76.06
76.07	03950	CV RESOURCE CENTER	0	0	0	0	0	76.07
76.08	03955	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.08
76.09	03956	LACTATION CLINIC	0	0	0	0	0	76.09
76.10	03957	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.10
76.11	03958	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.11
76.12	03959	ANTI COAGULATION CLINIC	440	440	0	440	0	76.12
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
91.00	09100	EMERGENCY	16,042	16,042	0	16,042	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
101.00	10100	HOME HEALTH AGENCY	1,358	1,358	0	1,358	0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0090

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

Worksheet B-1

Date/Time Prepared:  
5/30/2024 3:45 pm

Cost Center Description		MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUND)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT MEALS)						
		6.00	7.00	8.00	9.00	10.00						
<b>SPECIAL PURPOSE COST CENTERS</b>												
113.00	11300	INTEREST EXPENSE						113.00				
118.00	SUBTOTALS (SUM OF LINES 1 through 117)						292,655	272,508	575,002	267,119	199,277	118.00
<b>NONREIMBURSABLE COST CENTERS</b>												
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN					796	796	0	796	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES					13,697	13,697	0	13,697	0	192.00
192.01	19201	WORKING WELL					0	0	0	0	0	192.01
192.02	19202	PHYSICIANS' PRIVATE OFFICES					0	0	0	0	0	192.02
192.03	19203	MISC					0	0	0	0	0	192.03
194.00	07950	RESIDENTIAL					30,307	30,307	0	30,307	0	194.00
194.01	07954	OTHER NONREIMBURSABLE COST CENTERS					0	0	0	0	0	194.01
194.02	07952	PSYCHIATRIC					26,481	26,481	0	26,481	0	194.02
194.03	07953	CENTER OF HOPE					0	0	0	0	0	194.03
200.00	Cross Foot Adjustments											200.00
201.00	Negative Cost Centers											201.00
202.00	Cost to be allocated (per Wkst. B, Part I)		11,289,161	3,466,840	825,529	4,145,610	1,877,528				202.00	
203.00	Unit cost multiplier (Wkst. B, Part I)		31.019633	10.084209	1.435698	12.250621	9.421699				203.00	
204.00	Cost to be allocated (per Wkst. B, Part II)		1,507,323	489,136	4,753	159,629	138,327				204.00	
205.00	Unit cost multiplier (Wkst. B, Part II)		4.141725	1.422780	0.008266	0.471717	0.694144				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: 15-0090		Period: From 01/01/2023 To 12/31/2023		Worksheet B-1		
Date/Time Prepared: 5/30/2024 3:45 pm									
Cost Center Description	CAFETERIA (HOURS WORKED)	NURSING ADMINISTRATION (DIRECT NRSING)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)				
	11.00	13.00	14.00	15.00	16.00				
<b>GENERAL SERVICE COST CENTERS</b>									
1.00 00100	CAP REL COSTS-BLDG & FIXT								1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP								2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT								4.00
5.04 00593	OTHER ADMINISTRATIVE AND GENERAL								5.04
6.00 00600	MAINTENANCE & REPAIRS								6.00
7.00 00700	OPERATION OF PLANT								7.00
8.00 00800	LAUNDRY & LINEN SERVICE								8.00
9.00 00900	HOUSEKEEPING								9.00
10.00 01000	DIETARY								10.00
11.00 01100	CAFETERIA	1,268,039							11.00
13.00 01300	NURSING ADMINISTRATION	39,064	408,683						13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	16,621	196	676,345					14.00
15.00 01500	PHARMACY	35,287	0	15,648	100				15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	5,857	29	531	0	762,518,724			16.00
17.00 01700	SOCIAL SERVICE	0	0	0	0	0			17.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD	1,878	0	40	0	0			21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRV	2,080	0	0	0	0			22.00
23.00 02300	PARAMED ED PRGM - EMERGENCY MEDICINE	28	0	196	0	0			23.00
23.01 02301	PARAMED ED PRGM- LAB	1,792	0	965	0	0			23.01
23.02 02302	PARAMED ED PRGM- PHARMACY	8,430	0	0	0	0			23.02
23.03 02303	PARAMED ED PRGM- RADIOLOGY	0	0	0	0	0			23.03
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>									
30.00 03000	ADULTS & PEDIATRICS	361,570	164,727	70,179	0	72,772,173			30.00
31.00 03100	INTENSIVE CARE UNIT	45,101	40,303	5,190	0	10,388,787			31.00
32.00 03200	CORONARY CARE UNIT	0	0	0	0	0			32.00
33.00 03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0			33.00
35.00 02060	NEONATAL INTENSIVE CARE UNIT	19,717	18,354	905	0	1,848,900			35.00
41.00 04100	SUBPROVIDER - I RF	45,064	22,879	5,953	0	7,542,016			41.00
42.00 04200	SUBPROVIDER	0	0	0	0	0			42.00
43.00 04300	NURSERY	0	0	0	0	1,100,406			43.00
<b>ANCILLARY SERVICE COST CENTERS</b>									
50.00 05000	OPERATING ROOM	25,738	8,056	124,901	0	82,652,204			50.00
50.01 05001	OUTPATIENT SURGERY	14,482	14,097	12,146	0	3,793,528			50.01
51.00 05100	RECOVERY ROOM	7,824	6,044	997	0	16,151,657			51.00
53.00 05300	ANESTHESIOLOGY	1,781	0	237	0	18,447,799			53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	39,701	133	14,850	0	88,287,475			54.00
54.01 05401	RADIOLOGY-SPECIAL PROCEDURES	23,759	10,523	24,597	0	12,732,253			54.01
55.00 05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0			55.00
56.00 05600	RADIOISOTOPE	5,610	0	31	0	10,679,671			56.00
60.00 06000	LABORATORY	0	0	457	0	76,316,911			60.00
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	1,567,708			63.00
65.00 06500	RESPIRATORY THERAPY	36,047	0	5,163	0	13,697,800			65.00
66.00 06600	PHYSICAL THERAPY	69,476	324	15,012	0	26,059,110			66.00
67.00 06700	OCCUPATIONAL THERAPY	11,370	0	166	0	11,158,417			67.00
68.00 06800	SPEECH PATHOLOGY	7,337	0	111,978	0	8,807,913			68.00
69.00 06900	ELECTROCARDIOLOGY	18,630	5,956	10,486	0	26,818,703			69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	4,879	0	620	0	5,570,089			70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	52,969,791			71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	18,062,685			72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	100	39,660,597			73.00
76.00 03630	ULTRA SOUND	11,831	73	13,651	0	13,649,936			76.00
76.01 03951	PAIN CLINIC	12,704	11,722	7,023	0	9,751,124			76.01
76.02 03952	CATH LAB	35,179	23,370	73,519	0	49,155,719			76.02
76.03 03953	ACTIVITY THERAPEUTIC	39,043	20	1,403	0	3,118,083			76.03
76.04 03954	WOUND CARE CENTER	12,129	7,839	2,688	0	4,342,175			76.04
76.05 03340	BARITRIC CLINIC	15,991	7,170	3,818	0	829,472			76.05
76.06 03030	HEALTHY LIVING CENTER	0	0	0	0	0			76.06
76.07 03950	CV RESOURCE CENTER	0	0	0	0	0			76.07
76.08 03955	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0			76.08
76.09 03956	LACTATION CLINIC	0	0	0	0	0			76.09
76.10 03957	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0			76.10
76.11 03958	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0			76.11
76.12 03959	ANTI COAGULATION CLINIC	10,670	0	1,480	0	1,459,859			76.12
77.00 07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0			77.00
78.00 07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0			78.00
<b>OUTPATIENT SERVICE COST CENTERS</b>									
91.00 09100	EMERGENCY	102,018	50,679	57,370	0	62,786,727			91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)								92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>									
101.00 10100	HOME HEALTH AGENCY	62,186	8,959	37,936	0	10,339,036			101.00



COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0090

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

Worksheet B-1

Date/Time Prepared:  
5/30/2024 3:45 pm

Cost Center Description		CAFETERIA (HOURS WORK ED)	NURSING ADMINISTRATION (DIRECT NRS ING)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQ UISI)	MEDICAL RECORDS & LIBRARY (GROSS CHAR GES)	
		11.00	13.00	14.00	15.00	16.00	
102.00	10200 OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300 INTEREST EXPENSE						113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	1,150,874	401,453	620,136	100	762,518,724	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,088	0	40,883	0	0	190.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	18,359	1,211	5,334	0	0	192.00
192.01	19201 WORKING WELL	0	0	0	0	0	192.01
192.02	19202 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.02
192.03	19203 MISC	0	0	0	0	0	192.03
194.00	07950 RESIDENTIAL	96,699	6,019	9,992	0	0	194.00
194.01	07954 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.01
194.02	07952 PSYCHIATRIC	0	0	0	0	0	194.02
194.03	07953 CENTER OF HOPE	19	0	0	0	0	194.03
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	1,881,785	4,764,360	1,867,798	4,508,358	2,241,941	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	1.484012	11.657837	2.761605	45,083.580000	0.002940	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	175,200	51,230	293,020	128,939	130,806	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.138166	0.125354	0.433240	1,289.390000	0.000172	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: 15-0090

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

Worksheet B-1  
Date/Time Prepared:  
5/30/2024 3:45 pm

Cost Center Description	SOCIAL SERVICE (GROSS CHARGES)	INTERNS & RESIDENTS		PARAMED PRGM - EMERGENCY MEDICINE (ASSIGNED TIME)	PARAMED PRGM- LAB (ASSIGNED TIME)	
		SERVICES-SALARY & FRINGES (ASSIGNED TIME)	SERVICES-OTHER PRGM COSTS APPRV (ASSIGNED TIME)			
	17.00	21.00	22.00	23.00	23.01	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.04 00593 OTHER ADMINISTRATIVE AND GENERAL						5.04
6.00 00600 MAINTENANCE & REPAIRS						6.00
7.00 00700 OPERATION OF PLANT						7.00
8.00 00800 LAUNDRY & LINEN SERVICE						8.00
9.00 00900 HOUSEKEEPING						9.00
10.00 01000 DIETARY						10.00
11.00 01100 CAFETERIA						11.00
13.00 01300 NURSING ADMINISTRATION						13.00
14.00 01400 CENTRAL SERVICES & SUPPLY						14.00
15.00 01500 PHARMACY						15.00
16.00 01600 MEDICAL RECORDS & LIBRARY						16.00
17.00 01700 SOCIAL SERVICE	762,518,724					17.00
21.00 02100 I&R SERVICES-SALARY & FRINGES APPRVD	0	100				21.00
22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV	0		100			22.00
23.00 02300 PARAMED PRGM - EMERGENCY MEDICINE	0			100		23.00
23.01 02301 PARAMED PRGM- LAB	0				100	23.01
23.02 02302 PARAMED PRGM- PHARMACY	0					23.02
23.03 02303 PARAMED PRGM- RADIOLOGY	0					23.03
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000 ADULTS & PEDIATRICS	72,772,173	36	36	0	0	30.00
31.00 03100 INTENSIVE CARE UNIT	10,388,787	0	0	0	0	31.00
32.00 03200 CORONARY CARE UNIT	0	0	0	0	0	32.00
33.00 03300 BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
35.00 02060 NEONATAL INTENSIVE CARE UNIT	1,848,900	0	0	0	0	35.00
41.00 04100 SUBPROVIDER - IRF	7,542,016	0	0	0	0	41.00
42.00 04200 SUBPROVIDER	0	0	0	0	0	42.00
43.00 04300 NURSERY	1,100,406	0	0	0	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000 OPERATING ROOM	82,652,204	0	0	0	0	50.00
50.01 05001 OUTPATIENT SURGERY	3,793,528	0	0	0	0	50.01
51.00 05100 RECOVERY ROOM	16,151,657	0	0	0	0	51.00
53.00 05300 ANESTHESIOLOGY	18,447,799	0	0	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	88,287,475	0	0	0	0	54.00
54.01 05401 RADIOLOGY-SPECIAL PROCEDURES	12,732,253	0	0	0	0	54.01
55.00 05500 RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00 05600 RADIOISOTOPE	10,679,671	0	0	0	0	56.00
60.00 06000 LABORATORY	76,316,911	0	0	0	100	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	1,567,708	0	0	0	0	63.00
65.00 06500 RESPIRATORY THERAPY	13,697,800	0	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	26,059,110	0	0	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	11,158,417	0	0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	8,807,913	0	0	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	26,818,703	0	0	0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	5,570,089	0	0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	52,969,791	0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	18,062,685	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	39,660,597	0	0	0	0	73.00
76.00 03630 ULTRA SOUND	13,649,936	0	0	0	0	76.00
76.01 03951 PAIN CLINIC	9,751,124	0	0	0	0	76.01
76.02 03952 CATH LAB	49,155,719	0	0	0	0	76.02
76.03 03953 ACTIVITY THERAPEUTIC	3,118,083	0	0	0	0	76.03
76.04 03954 WOUND CARE CENTER	4,342,175	0	0	0	0	76.04
76.05 03340 BARIATRIC CLINIC	829,472	0	0	0	0	76.05
76.06 03030 HEALTHY LIVING CENTER	0	0	0	0	0	76.06
76.07 03950 CV RESOURCE CENTER	0	0	0	0	0	76.07
76.08 03955 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.08
76.09 03956 LACTATION CLINIC	0	0	0	0	0	76.09
76.10 03957 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.10
76.11 03958 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.11
76.12 03959 ANTI COAGULATION CLINIC	1,459,859	0	0	0	0	76.12
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77.00
78.00 07800 CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
91.00 09100 EMERGENCY	62,786,727	64	64	100	0	91.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0090

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

Worksheet B-1

Date/Time Prepared:  
5/30/2024 3:45 pm

Cost Center Description	SOCIAL SERVICE (GROSS CHARGES)	INTERNS & RESIDENTS		PARAMED PRGM - EMERGENCY MEDICINE (ASSIGNED TIME)	PARAMED PRGM- LAB (ASSIGNED TIME)			
		SERVICES-SALARY & FRINGES (ASSIGNED TIME)	SERVICES-OTHER PRGM COSTS APPRV (ASSIGNED TIME)					
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS	17.00	21.00	22.00	23.00	23.01	92.00
101.00	10100	HOME HEALTH AGENCY	10,339,036	0	0	0	0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	762,518,724	100	100	100	100	118.00
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	WORKING WELL	0	0	0	0	0	192.01
192.02	19202	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.02
192.03	19203	MISC	0	0	0	0	0	192.03
194.00	07950	RESIDENTIAL	0	0	0	0	0	194.00
194.01	07954	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.01
194.02	07952	PSYCHIATRIC	0	0	0	0	0	194.02
194.03	07953	CENTER OF HOPE	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	0	98,361	162,662	98,228	519,068	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	983.610000	1,626.620000	982.280000	5,190.680000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0	854	1,236	1,611	45,263	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	8.540000	12.360000	16.110000	452.630000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)				0	0	206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)				0.000000	0.000000	207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0090

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

Worksheet B-1

Date/Time Prepared:  
5/30/2024 3:45 pm

Cost Center Description		PARAMED PRGM- PHARMACY (ASSIGNED TIME)	PARAMED PRGM- RADIOLOGY (ASSIGNED TIME)	
		23.02	23.03	
<b>GENERAL SERVICE COST CENTERS</b>				
1.00	00100			1.00
2.00	00200			2.00
4.00	00400			4.00
5.04	00593			5.04
6.00	00600			6.00
7.00	00700			7.00
8.00	00800			8.00
9.00	00900			9.00
10.00	01000			10.00
11.00	01100			11.00
13.00	01300			13.00
14.00	01400			14.00
15.00	01500			15.00
16.00	01600			16.00
17.00	01700			17.00
21.00	02100			21.00
22.00	02200			22.00
23.00	02300			23.00
23.01	02301			23.01
23.02	02302	100		23.02
23.03	02303		0	23.03
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	03000	0	0	30.00
31.00	03100	0	0	31.00
32.00	03200	0	0	32.00
33.00	03300	0	0	33.00
35.00	02060	0	0	35.00
41.00	04100	0	0	41.00
42.00	04200	0	0	42.00
43.00	04300	0	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000	0	0	50.00
50.01	05001	0	0	50.01
51.00	05100	0	0	51.00
53.00	05300	0	0	53.00
54.00	05400	0	0	54.00
54.01	05401	0	0	54.01
55.00	05500	0	0	55.00
56.00	05600	0	0	56.00
60.00	06000	0	0	60.00
63.00	06300	0	0	63.00
65.00	06500	0	0	65.00
66.00	06600	0	0	66.00
67.00	06700	0	0	67.00
68.00	06800	0	0	68.00
69.00	06900	0	0	69.00
70.00	07000	0	0	70.00
71.00	07100	0	0	71.00
72.00	07200	0	0	72.00
73.00	07300	100	0	73.00
76.00	03630	0	0	76.00
76.01	03951	0	0	76.01
76.02	03952	0	0	76.02
76.03	03953	0	0	76.03
76.04	03954	0	0	76.04
76.05	03340	0	0	76.05
76.06	03030	0	0	76.06
76.07	03950	0	0	76.07
76.08	03955	0	0	76.08
76.09	03956	0	0	76.09
76.10	03957	0	0	76.10
76.11	03958	0	0	76.11
76.12	03959	0	0	76.12
77.00	07700	0	0	77.00
78.00	07800	0	0	78.00
<b>OUTPATIENT SERVICE COST CENTERS</b>				
91.00	09100	0	0	91.00
92.00	09200	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>				
101.00	10100	0	0	101.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0090

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

Worksheet B-1

Date/Time Prepared:  
5/30/2024 3:45 pm

Cost Center Description			PARAMED ED PRGM- PHARMACY (ASSIGNED TIME)	PARAMED ED PRGM- RADIOLOGY (ASSIGNED TIME)	
			23.02	23.03	
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	102.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE			113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	100	0	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
192.01	19201	WORKING WELL	0	0	192.01
192.02	19202	PHYSICIANS' PRIVATE OFFICES	0	0	192.02
192.03	19203	MISC	0	0	192.03
194.00	07950	RESIDENTIAL	0	0	194.00
194.01	07954	OTHER NONREIMBURSABLE COST CENTERS	0	0	194.01
194.02	07952	PSYCHIATRIC	0	0	194.02
194.03	07953	CENTER OF HOPE	0	0	194.03
200.00		Cross Foot Adjustments			200.00
201.00		Negative Cost Centers			201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	386,668	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	3,866.680000	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	8,442	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	84.420000	0.000000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)	0	0	206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)	0.000000	0.000000	207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 15-0090	Period: From 01/01/2023 To 12/31/2023	Worksheet C Part I Date/Time Prepared: 5/30/2024 3:45 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
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000 ADULTS & PEDIATRICS		43,425,611	0	43,425,611
31.00	03100 INTENSIVE CARE UNIT		6,001,644	0	6,001,644
32.00	03200 CORONARY CARE UNIT		0	0	0
33.00	03300 BURN INTENSIVE CARE UNIT		0	0	0
35.00	02060 NEONATAL INTENSIVE CARE UNIT		1,221,017	0	1,221,017
41.00	04100 SUBPROVIDER - IRF		4,555,491	0	4,555,491
42.00	04200 SUBPROVIDER		0	0	0
43.00	04300 NURSERY		1,784,715	0	1,784,715
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000 OPERATING ROOM		7,825,060	0	7,825,060
50.01	05001 OUTPATIENT SURGERY		2,775,307	0	2,775,307
51.00	05100 RECOVERY ROOM		1,379,593	0	1,379,593
53.00	05300 ANESTHESIOLOGY		95,192	0	95,192
54.00	05400 RADIOLOGY-DIAGNOSTIC		7,658,847	0	7,658,847
54.01	05401 RADIOLOGY-SPECIAL PROCEDURES		2,710,330	0	2,710,330
55.00	05500 RADIOLOGY-THERAPEUTIC		0	0	0
56.00	05600 RADIOISOTOPE		1,137,644	0	1,137,644
60.00	06000 LABORATORY		10,578,146	0	10,578,146
63.00	06300 BLOOD STORING, PROCESSING & TRANS.		729,259	0	729,259
65.00	06500 RESPIRATORY THERAPY	0	4,075,246	0	4,075,246
66.00	06600 PHYSICAL THERAPY	0	6,555,636	0	6,555,636
67.00	06700 OCCUPATIONAL THERAPY	0	1,031,851	0	1,031,851
68.00	06800 SPEECH PATHOLOGY	0	1,263,002	0	1,263,002
69.00	06900 ELECTROCARDIOLOGY		2,197,231	0	2,197,231
70.00	07000 ELECTROENCEPHALOGRAPHY		826,873	0	826,873
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		17,354,709	0	17,354,709
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS		4,611,518	0	4,611,518
73.00	07300 DRUGS CHARGED TO PATIENTS		10,947,739	0	10,947,739
76.00	03630 ULTRA SOUND		1,368,423	0	1,368,423
76.01	03951 PAIN CLINIC		2,235,980	0	2,235,980
76.02	03952 CATH LAB		5,505,746	0	5,505,746
76.03	03953 ACTIVITY THERAPEUTIC		3,126,589	0	3,126,589
76.04	03954 WOUND CARE CENTER		1,559,403	0	1,559,403
76.05	03340 BARIATRIC CLINIC		1,189,194	0	1,189,194
76.06	03030 HEALTHY LIVING CENTER		0	0	0
76.07	03950 CV RESOURCE CENTER		0	0	0
76.08	03955 OTHER ANCILLARY SERVICE COST CENTERS		0	0	0
76.09	03956 LACTATION CLINIC		0	0	0
76.10	03957 OTHER ANCILLARY SERVICE COST CENTERS		0	0	0
76.11	03958 OTHER ANCILLARY SERVICE COST CENTERS		0	0	0
76.12	03959 ANTI COAGULATION CLINIC		1,019,812	0	1,019,812
77.00	07700 ALLOGENEIC STEM CELL ACQUISITION		0	0	0
78.00	07800 CAR T-CELL IMMUNOTHERAPY		0	0	0
<b>OUTPATIENT SERVICE COST CENTERS</b>					
91.00	09100 EMERGENCY		10,570,338	0	10,570,338
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART		4,407,652	0	4,407,652
<b>OTHER REIMBURSABLE COST CENTERS</b>					
101.00	10100 HOME HEALTH AGENCY		13,370,290	0	13,370,290
102.00	10200 OPIOID TREATMENT PROGRAM		0	0	0
<b>SPECIAL PURPOSE COST CENTERS</b>					
113.00	11300 INTEREST EXPENSE				
200.00	Subtotal (see instructions)		185,095,088	0	185,095,088
201.00	Less Observation Beds		4,407,652	0	4,407,652
202.00	Total (see instructions)		180,687,436	0	180,687,436

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 15-0090		Period: From 01/01/2023 To 12/31/2023		Worksheet C Part I Date/Time Prepared: 5/30/2024 3:45 pm		
			Title XVIII			Hospital		PPS	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
			Inpatient	Outpatient	Total (col. 6 + col. 7)				
			6.00	7.00	8.00	9.00	10.00		
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>									
30.00	03000	ADULTS & PEDIATRICS	63,468,258		63,468,258				30.00
31.00	03100	INTENSIVE CARE UNIT	10,388,787		10,388,787				31.00
32.00	03200	CORONARY CARE UNIT	0		0				32.00
33.00	03300	BURN INTENSIVE CARE UNIT	0		0				33.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	1,848,900		1,848,900				35.00
41.00	04100	SUBPROVIDER - I RF	7,542,016		7,542,016				41.00
42.00	04200	SUBPROVIDER	0		0				42.00
43.00	04300	NURSERY	1,100,406		1,100,406				43.00
<b>ANCILLARY SERVICE COST CENTERS</b>									
50.00	05000	OPERATING ROOM	34,061,809	48,590,395	82,652,204	0.094675	0.000000		50.00
50.01	05001	OUTPATIENT SURGERY	1,815,179	1,978,349	3,793,528	0.731590	0.000000		50.01
51.00	05100	RECOVERY ROOM	3,358,747	12,792,910	16,151,657	0.085415	0.000000		51.00
53.00	05300	ANESTHESIOLOGY	6,993,558	11,454,241	18,447,799	0.005160	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	27,304,592	60,982,883	88,287,475	0.086749	0.000000		54.00
54.01	05401	RADIOLOGY-SPECIAL PROCEDURES	5,148,269	7,583,984	12,732,253	0.212871	0.000000		54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0.000000	0.000000		55.00
56.00	05600	RADIOISOTOPE	1,462,800	9,216,871	10,679,671	0.106524	0.000000		56.00
60.00	06000	LABORATORY	37,511,168	38,805,743	76,316,911	0.138608	0.000000		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	1,235,537	332,171	1,567,708	0.465175	0.000000		63.00
65.00	06500	RESPIRATORY THERAPY	12,931,033	766,767	13,697,800	0.297511	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	6,453,385	19,605,725	26,059,110	0.251568	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	5,569,626	5,588,791	11,158,417	0.092473	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	2,989,638	5,818,275	8,807,913	0.143394	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	9,470,998	17,347,705	26,818,703	0.081929	0.000000		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	560,292	5,009,797	5,570,089	0.148449	0.000000		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	25,040,400	27,929,391	52,969,791	0.327634	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	7,441,880	10,620,805	18,062,685	0.255306	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	27,478,045	12,182,552	39,660,597	0.276036	0.000000		73.00
76.00	03630	ULTRA SOUND	4,090,978	9,558,958	13,649,936	0.100251	0.000000		76.00
76.01	03951	PAIN CLINIC	102,132	9,648,992	9,751,124	0.229305	0.000000		76.01
76.02	03952	CATH LAB	16,387,210	32,768,509	49,155,719	0.112006	0.000000		76.02
76.03	03953	ACTIVITY THERAPEUTIC	2,992,605	125,478	3,118,083	1.002728	0.000000		76.03
76.04	03954	WOUND CARE CENTER	147,826	4,194,349	4,342,175	0.359129	0.000000		76.04
76.05	03340	BARIATRIC CLINIC	1,907	827,565	829,472	1.433676	0.000000		76.05
76.06	03030	HEALTHY LIVING CENTER	0	0	0	0.000000	0.000000		76.06
76.07	03950	CV RESOURCE CENTER	0	0	0	0.000000	0.000000		76.07
76.08	03955	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0.000000	0.000000		76.08
76.09	03956	LACTATION CLINIC	0	0	0	0.000000	0.000000		76.09
76.10	03957	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0.000000	0.000000		76.10
76.11	03958	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0.000000	0.000000		76.11
76.12	03959	ANTI COAGULATION CLINIC	8,705	1,451,154	1,459,859	0.698569	0.000000		76.12
77.00	07700	ALLOGENEIC STEM CELL 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
<b>OUTPATIENT SERVICE COST CENTERS</b>									
91.00	09100	EMERGENCY	16,944,805	45,841,922	62,786,727	0.168353	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	3,095,815	6,208,100	9,303,915	0.473742	0.000000		92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>									
101.00	10100	HOME HEALTH AGENCY	0	10,339,036	10,339,036				101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0				102.00
<b>SPECIAL PURPOSE COST CENTERS</b>									
113.00	11300	INTEREST EXPENSE							113.00
200.00		Subtotal (see instructions)	344,947,306	417,571,418	762,518,724				200.00
201.00		Less Observation Beds							201.00
202.00		Total (see instructions)	344,947,306	417,571,418	762,518,724				202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 15-0090	Period: From 01/01/2023 To 12/31/2023	Worksheet C Part I Date/Time Prepared: 5/30/2024 3:45 pm
			Title XVIII	Hospital	PPS
Cost Center Description			PPS Inpatient Ratio		
			11.00		
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
32.00	03200	CORONARY CARE UNIT			32.00
33.00	03300	BURN INTENSIVE CARE UNIT			33.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT			35.00
41.00	04100	SUBPROVIDER - I RF			41.00
42.00	04200	SUBPROVIDER			42.00
43.00	04300	NURSERY			43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	0.094675		50.00
50.01	05001	OUTPATIENT SURGERY	0.731590		50.01
51.00	05100	RECOVERY ROOM	0.085415		51.00
53.00	05300	ANESTHESIOLOGY	0.005160		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.086749		54.00
54.01	05401	RADIOLOGY-SPECIAL PROCEDURES	0.212871		54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000		55.00
56.00	05600	RADIOISOTOPE	0.106524		56.00
60.00	06000	LABORATORY	0.138608		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.465175		63.00
65.00	06500	RESPIRATORY THERAPY	0.297511		65.00
66.00	06600	PHYSICAL THERAPY	0.251568		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.092473		67.00
68.00	06800	SPEECH PATHOLOGY	0.143394		68.00
69.00	06900	ELECTROCARDIOLOGY	0.081929		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.148449		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.327634		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.255306		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.276036		73.00
76.00	03630	ULTRA SOUND	0.100251		76.00
76.01	03951	PAIN CLINIC	0.229305		76.01
76.02	03952	CATH LAB	0.112006		76.02
76.03	03953	ACTIVITY THERAPEUTIC	1.002728		76.03
76.04	03954	WOUND CARE CENTER	0.359129		76.04
76.05	03340	BARIATRIC CLINIC	1.433676		76.05
76.06	03030	HEALTHY LIVING CENTER	0.000000		76.06
76.07	03950	CV RESOURCE CENTER	0.000000		76.07
76.08	03955	OTHER ANCILLARY SERVICE COST CENTERS	0.000000		76.08
76.09	03956	LACTATION CLINIC	0.000000		76.09
76.10	03957	OTHER ANCILLARY SERVICE COST CENTERS	0.000000		76.10
76.11	03958	OTHER ANCILLARY SERVICE COST CENTERS	0.000000		76.11
76.12	03959	ANTICOAGULATION CLINIC	0.698569		76.12
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0.000000		77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000		78.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
91.00	09100	EMERGENCY	0.168353		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.473742		92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
101.00	10100	HOME HEALTH AGENCY			101.00
102.00	10200	OPIOID TREATMENT PROGRAM			102.00
<b>SPECIAL PURPOSE COST CENTERS</b>					
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00



COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 15-0090	Period: From 01/01/2023 To 12/31/2023	Worksheet C Part I Date/Time Prepared: 5/30/2024 3:45 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
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000 ADULTS & PEDIATRICS		43,425,611	0	43,425,611
31.00	03100 INTENSIVE CARE UNIT		6,001,644	0	6,001,644
32.00	03200 CORONARY CARE UNIT		0	0	0
33.00	03300 BURN INTENSIVE CARE UNIT		0	0	0
35.00	02060 NEONATAL INTENSIVE CARE UNIT		1,221,017	0	1,221,017
41.00	04100 SUBPROVIDER - IRF		4,555,491	0	4,555,491
42.00	04200 SUBPROVIDER		0	0	0
43.00	04300 NURSERY		1,784,715	0	1,784,715
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000 OPERATING ROOM		7,825,060	0	7,825,060
50.01	05001 OUTPATIENT SURGERY		2,775,307	0	2,775,307
51.00	05100 RECOVERY ROOM		1,379,593	0	1,379,593
53.00	05300 ANESTHESIOLOGY		95,192	0	95,192
54.00	05400 RADIOLOGY-DIAGNOSTIC		7,658,847	0	7,658,847
54.01	05401 RADIOLOGY-SPECIAL PROCEDURES		2,710,330	0	2,710,330
55.00	05500 RADIOLOGY-THERAPEUTIC		0	0	0
56.00	05600 RADIOISOTOPE		1,137,644	0	1,137,644
60.00	06000 LABORATORY		10,578,146	0	10,578,146
63.00	06300 BLOOD STORING, PROCESSING & TRANS.		729,259	0	729,259
65.00	06500 RESPIRATORY THERAPY	0	4,075,246	0	4,075,246
66.00	06600 PHYSICAL THERAPY	0	6,555,636	0	6,555,636
67.00	06700 OCCUPATIONAL THERAPY	0	1,031,851	0	1,031,851
68.00	06800 SPEECH PATHOLOGY	0	1,263,002	0	1,263,002
69.00	06900 ELECTROCARDIOLOGY		2,197,231	0	2,197,231
70.00	07000 ELECTROENCEPHALOGRAPHY		826,873	0	826,873
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		17,354,709	0	17,354,709
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS		4,611,518	0	4,611,518
73.00	07300 DRUGS CHARGED TO PATIENTS		10,947,739	0	10,947,739
76.00	03630 ULTRA SOUND		1,368,423	0	1,368,423
76.01	03951 PAIN CLINIC		2,235,980	0	2,235,980
76.02	03952 CATH LAB		5,505,746	0	5,505,746
76.03	03953 ACTIVITY THERAPEUTIC		3,126,589	0	3,126,589
76.04	03954 WOUND CARE CENTER		1,559,403	0	1,559,403
76.05	03340 BARIATRIC CLINIC		1,189,194	0	1,189,194
76.06	03030 HEALTHY LIVING CENTER		0	0	0
76.07	03950 CV RESOURCE CENTER		0	0	0
76.08	03955 OTHER ANCILLARY SERVICE COST CENTERS		0	0	0
76.09	03956 LACTATION CLINIC		0	0	0
76.10	03957 OTHER ANCILLARY SERVICE COST CENTERS		0	0	0
76.11	03958 OTHER ANCILLARY SERVICE COST CENTERS		0	0	0
76.12	03959 ANTI COAGULATION CLINIC		1,019,812	0	1,019,812
77.00	07700 ALLOGENEIC STEM CELL ACQUISITION		0	0	0
78.00	07800 CAR T-CELL IMMUNOTHERAPY		0	0	0
<b>OUTPATIENT SERVICE COST CENTERS</b>					
91.00	09100 EMERGENCY		10,570,338	0	10,570,338
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART		4,407,652	0	4,407,652
<b>OTHER REIMBURSABLE COST CENTERS</b>					
101.00	10100 HOME HEALTH AGENCY		13,370,290	0	13,370,290
102.00	10200 OPIOID TREATMENT PROGRAM		0	0	0
<b>SPECIAL PURPOSE COST CENTERS</b>					
113.00	11300 INTEREST EXPENSE				
200.00	Subtotal (see instructions)		185,095,088	0	185,095,088
201.00	Less Observation Beds		4,407,652	0	4,407,652
202.00	Total (see instructions)		180,687,436	0	180,687,436

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 15-0090		Period: From 01/01/2023 To 12/31/2023		Worksheet C Part I Date/Time Prepared: 5/30/2024 3:45 pm		
			Title XIX			Hospital		Cost	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
			Inpatient	Outpatient	Total (col. 6 + col. 7)				
			6.00	7.00	8.00	9.00	10.00		
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>									
30.00	03000	ADULTS & PEDIATRICS	63,468,258		63,468,258				30.00
31.00	03100	INTENSIVE CARE UNIT	10,388,787		10,388,787				31.00
32.00	03200	CORONARY CARE UNIT	0		0				32.00
33.00	03300	BURN INTENSIVE CARE UNIT	0		0				33.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	1,848,900		1,848,900				35.00
41.00	04100	SUBPROVIDER - I RF	7,542,016		7,542,016				41.00
42.00	04200	SUBPROVIDER	0		0				42.00
43.00	04300	NURSERY	1,100,406		1,100,406				43.00
<b>ANCILLARY SERVICE COST CENTERS</b>									
50.00	05000	OPERATING ROOM	34,061,809	48,590,395	82,652,204	0.094675	0.094675		50.00
50.01	05001	OUTPATIENT SURGERY	1,815,179	1,978,349	3,793,528	0.731590	0.731590		50.01
51.00	05100	RECOVERY ROOM	3,358,747	12,792,910	16,151,657	0.085415	0.085415		51.00
53.00	05300	ANESTHESIOLOGY	6,993,558	11,454,241	18,447,799	0.005160	0.005160		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	27,304,592	60,982,883	88,287,475	0.086749	0.086749		54.00
54.01	05401	RADIOLOGY-SPECIAL PROCEDURES	5,148,269	7,583,984	12,732,253	0.212871	0.212871		54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0.000000	0.000000		55.00
56.00	05600	RADIOISOTOPE	1,462,800	9,216,871	10,679,671	0.106524	0.106524		56.00
60.00	06000	LABORATORY	37,511,168	38,805,743	76,316,911	0.138608	0.138608		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	1,235,537	332,171	1,567,708	0.465175	0.465175		63.00
65.00	06500	RESPIRATORY THERAPY	12,931,033	766,767	13,697,800	0.297511	0.297511		65.00
66.00	06600	PHYSICAL THERAPY	6,453,385	19,605,725	26,059,110	0.251568	0.251568		66.00
67.00	06700	OCCUPATIONAL THERAPY	5,569,626	5,588,791	11,158,417	0.092473	0.092473		67.00
68.00	06800	SPEECH PATHOLOGY	2,989,638	5,818,275	8,807,913	0.143394	0.143394		68.00
69.00	06900	ELECTROCARDIOLOGY	9,470,998	17,347,705	26,818,703	0.081929	0.081929		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	560,292	5,009,797	5,570,089	0.148449	0.148449		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	25,040,400	27,929,391	52,969,791	0.327634	0.327634		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	7,441,880	10,620,805	18,062,685	0.255306	0.255306		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	27,478,045	12,182,552	39,660,597	0.276036	0.276036		73.00
76.00	03630	ULTRA SOUND	4,090,978	9,558,958	13,649,936	0.100251	0.100251		76.00
76.01	03951	PAIN CLINIC	102,132	9,648,992	9,751,124	0.229305	0.229305		76.01
76.02	03952	CATH LAB	16,387,210	32,768,509	49,155,719	0.112006	0.112006		76.02
76.03	03953	ACTIVITY THERAPEUTIC	2,992,605	125,478	3,118,083	1.002728	1.002728		76.03
76.04	03954	WOUND CARE CENTER	147,826	4,194,349	4,342,175	0.359129	0.359129		76.04
76.05	03340	BARIATRIC CLINIC	1,907	827,565	829,472	1.433676	1.433676		76.05
76.06	03030	HEALTHY LIVING CENTER	0	0	0	0.000000	0.000000		76.06
76.07	03950	CV RESOURCE CENTER	0	0	0	0.000000	0.000000		76.07
76.08	03955	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0.000000	0.000000		76.08
76.09	03956	LACTATION CLINIC	0	0	0	0.000000	0.000000		76.09
76.10	03957	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0.000000	0.000000		76.10
76.11	03958	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0.000000	0.000000		76.11
76.12	03959	ANTI COAGULATION CLINIC	8,705	1,451,154	1,459,859	0.698569	0.698569		76.12
77.00	07700	ALLOGENEIC STEM CELL 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
<b>OUTPATIENT SERVICE COST CENTERS</b>									
91.00	09100	EMERGENCY	16,944,805	45,841,922	62,786,727	0.168353	0.168353		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	3,095,815	6,208,100	9,303,915	0.473742	0.473742		92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>									
101.00	10100	HOME HEALTH AGENCY	0	10,339,036	10,339,036				101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0				102.00
<b>SPECIAL PURPOSE COST CENTERS</b>									
113.00	11300	INTEREST EXPENSE							113.00
200.00		Subtotal (see instructions)	344,947,306	417,571,418	762,518,724				200.00
201.00		Less Observation Beds							201.00
202.00		Total (see instructions)	344,947,306	417,571,418	762,518,724				202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 15-0090	Period: From 01/01/2023 To 12/31/2023	Worksheet C Part I Date/Time Prepared: 5/30/2024 3:45 pm
			Title XIX	Hospital	Cost
Cost Center Description			PPS Inpatient Ratio		
			11.00		
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
32.00	03200	CORONARY CARE UNIT			32.00
33.00	03300	BURN INTENSIVE CARE UNIT			33.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT			35.00
41.00	04100	SUBPROVIDER - I RF			41.00
42.00	04200	SUBPROVIDER			42.00
43.00	04300	NURSERY			43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	0.000000		50.00
50.01	05001	OUTPATIENT SURGERY	0.000000		50.01
51.00	05100	RECOVERY ROOM	0.000000		51.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
54.01	05401	RADIOLOGY-SPECIAL PROCEDURES	0.000000		54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000		55.00
56.00	05600	RADIOISOTOPE	0.000000		56.00
60.00	06000	LABORATORY	0.000000		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000		63.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.00	03630	ULTRA SOUND	0.000000		76.00
76.01	03951	PAIN CLINIC	0.000000		76.01
76.02	03952	CATH LAB	0.000000		76.02
76.03	03953	ACTIVITY THERAPEUTIC	0.000000		76.03
76.04	03954	WOUND CARE CENTER	0.000000		76.04
76.05	03340	BARIATRIC CLINIC	0.000000		76.05
76.06	03030	HEALTHY LIVING CENTER	0.000000		76.06
76.07	03950	CV RESOURCE CENTER	0.000000		76.07
76.08	03955	OTHER ANCILLARY SERVICE COST CENTERS	0.000000		76.08
76.09	03956	LACTATION CLINIC	0.000000		76.09
76.10	03957	OTHER ANCILLARY SERVICE COST CENTERS	0.000000		76.10
76.11	03958	OTHER ANCILLARY SERVICE COST CENTERS	0.000000		76.11
76.12	03959	ANTI COAGULATION CLINIC	0.000000		76.12
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0.000000		77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000		78.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
101.00	10100	HOME HEALTH AGENCY			101.00
102.00	10200	OPIOID TREATMENT PROGRAM			102.00
<b>SPECIAL PURPOSE COST CENTERS</b>					
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS	Provider CCN: 15-0090	Period: From 01/01/2023 To 12/31/2023	Worksheet D Part I Date/Time Prepared: 5/30/2024 3:45 pm
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Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	4.00	5.00	
30.00	ADULTS & PEDIATRICS	2,671,724	0	2,671,724	27,557	96.95	30.00
31.00	INTENSIVE CARE UNIT	380,387		380,387	2,392	159.02	31.00
32.00	CORONARY CARE UNIT	0		0	0	0.00	32.00
33.00	BURN INTENSIVE CARE UNIT	0		0	0	0.00	33.00
35.00	NEONATAL INTENSIVE CARE UNIT	34,668		34,668	350	99.05	35.00
41.00	SUBPROVIDER - IRF	213,206	0	213,206	3,964	53.79	41.00
42.00	SUBPROVIDER	0	0	0	0	0.00	42.00
43.00	NURSERY	10,847		10,847	704	15.41	43.00
200.00	Total (lines 30 through 199)	3,310,832		3,310,832	34,967		200.00
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
INPATIENT ROUTINE SERVICE COST CENTERS		6.00	7.00				
30.00	ADULTS & PEDIATRICS	7,090	687,376				
31.00	INTENSIVE CARE UNIT	837	133,100				
32.00	CORONARY CARE UNIT	0	0				
33.00	BURN INTENSIVE CARE UNIT	0	0				
35.00	NEONATAL INTENSIVE CARE UNIT	0	0				
41.00	SUBPROVIDER - IRF	2,694	144,910				
42.00	SUBPROVIDER	0	0				
43.00	NURSERY	0	0				
200.00	Total (lines 30 through 199)	10,621	965,386				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 15-0090	Period: From 01/01/2023 To 12/31/2023	Worksheet D Part II Date/Time Prepared: 5/30/2024 3:45 pm
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Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Hospital		Capital Costs (column 3 x column 4)	
					Inpatient Program Charges	PPS		
		1.00	2.00	3.00	4.00	5.00		
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	1,488,413	82,652,204	0.018008	7,929,978	142,803	50.00
50.01	05001	OUTPATIENT SURGERY	387,916	3,793,528	0.102257	781,145	79,878	50.01
51.00	05100	RECOVERY ROOM	190,545	16,151,657	0.011797	769,528	9,078	51.00
53.00	05300	ANESTHESIOLOGY	4,536	18,447,799	0.000246	1,735,368	427	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,746,011	88,287,475	0.019776	10,919,638	215,947	54.00
54.01	05401	RADIOLOGY-SPECIAL PROCEDURES	153,270	12,732,253	0.012038	1,551,649	18,679	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0.000000	0	0	55.00
56.00	05600	RADIOISOTOPE	221,609	10,679,671	0.020751	589,328	12,229	56.00
60.00	06000	LABORATORY	231,012	76,316,911	0.003027	12,417,029	37,586	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	72,108	1,567,708	0.045996	421,014	19,365	63.00
65.00	06500	RESPIRATORY THERAPY	182,615	13,697,800	0.013332	5,001,716	66,683	65.00
66.00	06600	PHYSICAL THERAPY	131,462	26,059,110	0.005045	1,601,775	8,081	66.00
67.00	06700	OCCUPATIONAL THERAPY	22,785	11,158,417	0.002042	1,314,391	2,684	67.00
68.00	06800	SPEECH PATHOLOGY	82,417	8,807,913	0.009357	686,072	6,420	68.00
69.00	06900	ELECTROCARDIOLOGY	311,116	26,818,703	0.011601	3,969,148	46,046	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	136,417	5,570,089	0.024491	262,348	6,425	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	108,143	52,969,791	0.002042	8,550,864	17,461	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	29,354	18,062,685	0.001625	2,260,164	3,673	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	169,941	39,660,597	0.004285	8,323,700	35,667	73.00
76.00	03630	ULTRA SOUND	165,937	13,649,936	0.012157	1,533,387	18,641	76.00
76.01	03951	PAIN CLINIC	329,781	9,751,124	0.033820	22,736	769	76.01
76.02	03952	CATH LAB	633,959	49,155,719	0.012897	6,486,892	83,661	76.02
76.03	03953	ACTIVITY THERAPEUTIC	161,666	3,118,083	0.051848	195,232	10,122	76.03
76.04	03954	WOUND CARE CENTER	171,114	4,342,175	0.039407	61,108	2,408	76.04
76.05	03340	BARIATRIC CLINIC	59,771	829,472	0.072059	652	47	76.05
76.06	03030	HEALTHY LIVING CENTER	0	0	0.000000	0	0	76.06
76.07	03950	CV RESOURCE CENTER	0	0	0.000000	0	0	76.07
76.08	03955	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0.000000	0	0	76.08
76.09	03956	LACTATION CLINIC	0	0	0.000000	0	0	76.09
76.10	03957	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0.000000	0	0	76.10
76.11	03958	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0.000000	0	0	76.11
76.12	03959	ANTI COAGULATION CLINIC	18,909	1,459,859	0.012953	2,066	27	76.12
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0.000000	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0.000000	0	0	78.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
91.00	09100	EMERGENCY	568,234	62,786,727	0.009050	6,337,608	57,355	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	271,176	9,303,915	0.029146	1,440,353	41,981	92.00
200.00		Total (lines 50 through 199)	8,050,217	667,831,321		85,164,889	944,143	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0090	Period: From 01/01/2023 To 12/31/2023	Worksheet D Part III Date/Time Prepared: 5/30/2024 3:45 pm
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Cost Center Description			Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost		
			1A	1.00	2A	2.00	3.00		
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00	
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00	
32.00	03200	CORONARY CARE UNIT	0	0	0	0	0	32.00	
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00	
35.00	02060	NEONATAL INTENSIVE CARE UNIT	0	0	0	0	0	35.00	
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00	
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00	
43.00	04300	NURSERY	0	0	0	0	0	43.00	
200.00		Total (lines 30 through 199)	0	0	0	0	0	200.00	
Cost Center Description			Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days		
			4.00	5.00	6.00	7.00	8.00		
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	0	0	27,557	0.00	7,090	30.00	
31.00	03100	INTENSIVE CARE UNIT	0	0	2,392	0.00	837	31.00	
32.00	03200	CORONARY CARE UNIT	0	0	0	0.00	0	32.00	
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0.00	0	33.00	
35.00	02060	NEONATAL INTENSIVE CARE UNIT	0	0	350	0.00	0	35.00	
41.00	04100	SUBPROVIDER - IRF	0	0	3,964	0.00	2,694	41.00	
42.00	04200	SUBPROVIDER	0	0	0	0.00	0	42.00	
43.00	04300	NURSERY	0	0	704	0.00	0	43.00	
200.00		Total (lines 30 through 199)	0	0	34,967	0.00	10,621	200.00	
Cost Center Description			Inpatient Program Pass-Through Cost (col. 7 x col. 8)						
			9.00						
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	0						30.00
31.00	03100	INTENSIVE CARE UNIT	0						31.00
32.00	03200	CORONARY CARE UNIT	0						32.00
33.00	03300	BURN INTENSIVE CARE UNIT	0						33.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	0						35.00
41.00	04100	SUBPROVIDER - IRF	0						41.00
42.00	04200	SUBPROVIDER	0						42.00
43.00	04300	NURSERY	0						43.00
200.00		Total (lines 30 through 199)	0						200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0090	Period: From 01/01/2023 To 12/31/2023	Worksheet D Part IV Date/Time Prepared: 5/30/2024 3:45 pm
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Cost Center Description	Title XVIII			Hospital		PPS	
	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health		
	1.00	2A	2.00	3A	3.00		
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
50.01	05001	OUTPATIENT SURGERY	0	0	0	0	50.01
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
54.01	05401	RADIOLOGY-SPECIAL PROCEDURES	0	0	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	56.00
60.00	06000	LABORATORY	0	0	0	519,068	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	386,668	73.00
76.00	03630	ULTRA SOUND	0	0	0	0	76.00
76.01	03951	PAIN CLINIC	0	0	0	0	76.01
76.02	03952	CATH LAB	0	0	0	0	76.02
76.03	03953	ACTIVITY THERAPEUTIC	0	0	0	0	76.03
76.04	03954	WOUND CARE CENTER	0	0	0	0	76.04
76.05	03340	BARIATRIC CLINIC	0	0	0	0	76.05
76.06	03030	HEALTHY LIVING CENTER	0	0	0	0	76.06
76.07	03950	CV RESOURCE CENTER	0	0	0	0	76.07
76.08	03955	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	76.08
76.09	03956	LACTATION CLINIC	0	0	0	0	76.09
76.10	03957	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	76.10
76.11	03958	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	76.11
76.12	03959	ANTI COAGULATION CLINIC	0	0	0	0	76.12
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	78.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
91.00	09100	EMERGENCY	0	0	0	98,228	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	92.00
200.00		Total (lines 50 through 199)	0	0	0	1,003,964	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0090	Period: From 01/01/2023 To 12/31/2023	Worksheet D Part IV Date/Time Prepared: 5/30/2024 3:45 pm
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Cost Center Description	All Other Medical Education Cost	Total Cost (sum of col. 1, 2, 3, and 4)	Total Outpatient Cost (sum of col. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
	4.00	5.00	6.00	7.00	8.00	
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000 OPERATING ROOM	0	0	0	82,652,204	0.000000	50.00
50.01 05001 OUTPATIENT SURGERY	0	0	0	3,793,528	0.000000	50.01
51.00 05100 RECOVERY ROOM	0	0	0	16,151,657	0.000000	51.00
53.00 05300 ANESTHESIOLOGY	0	0	0	18,447,799	0.000000	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	0	88,287,475	0.000000	54.00
54.01 05401 RADIOLOGY-SPECIAL PROCEDURES	0	0	0	12,732,253	0.000000	54.01
55.00 05500 RADIOLOGY-THERAPEUTIC	0	0	0	0	0.000000	55.00
56.00 05600 RADIOISOTOPE	0	0	0	10,679,671	0.000000	56.00
60.00 06000 LABORATORY	0	519,068	519,068	76,316,911	0.006801	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	1,567,708	0.000000	63.00
65.00 06500 RESPIRATORY THERAPY	0	0	0	13,697,800	0.000000	65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	26,059,110	0.000000	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	11,158,417	0.000000	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0	8,807,913	0.000000	68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	0	26,818,703	0.000000	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	5,570,089	0.000000	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	52,969,791	0.000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	18,062,685	0.000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	386,668	386,668	39,660,597	0.009749	73.00
76.00 03630 ULTRA SOUND	0	0	0	13,649,936	0.000000	76.00
76.01 03951 PAIN CLINIC	0	0	0	9,751,124	0.000000	76.01
76.02 03952 CATH LAB	0	0	0	49,155,719	0.000000	76.02
76.03 03953 ACTIVITY THERAPEUTIC	0	0	0	3,118,083	0.000000	76.03
76.04 03954 WOUND CARE CENTER	0	0	0	4,342,175	0.000000	76.04
76.05 03340 BARIATRIC CLINIC	0	0	0	829,472	0.000000	76.05
76.06 03030 HEALTHY LIVING CENTER	0	0	0	0	0.000000	76.06
76.07 03950 CV RESOURCE CENTER	0	0	0	0	0.000000	76.07
76.08 03955 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0.000000	76.08
76.09 03956 LACTATION CLINIC	0	0	0	0	0.000000	76.09
76.10 03957 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0.000000	76.10
76.11 03958 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0.000000	76.11
76.12 03959 ANTI COAGULATION CLINIC	0	0	0	1,459,859	0.000000	76.12
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0.000000	77.00
78.00 07800 CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0.000000	78.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
91.00 09100 EMERGENCY	0	98,228	98,228	62,786,727	0.001564	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	9,303,915	0.000000	92.00
200.00 Total (lines 50 through 199)	0	1,003,964	1,003,964	667,831,321		200.00



APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0090	Period: From 01/01/2023 To 12/31/2023	Worksheet D Part IV Date/Time Prepared: 5/30/2024 3:45 pm
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Cost Center Description		Title XVIII					
		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	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	0.000000	7,929,978	0	8,995,236	0	50.00
50.01	05001 OUTPATIENT SURGERY	0.000000	781,145	0	408,750	0	50.01
51.00	05100 RECOVERY ROOM	0.000000	769,528	0	2,775,281	0	51.00
53.00	05300 ANESTHESIOLOGY	0.000000	1,735,368	0	1,873,138	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000	10,919,638	0	13,787,285	0	54.00
54.01	05401 RADIOLOGY-SPECIAL PROCEDURES	0.000000	1,551,649	0	2,044,530	0	54.01
55.00	05500 RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	0	55.00
56.00	05600 RADIOISOTOPE	0.000000	589,328	0	3,425,150	0	56.00
60.00	06000 LABORATORY	0.006801	12,417,029	84,448	2,178,300	14,815	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.000000	421,014	0	50,891	0	63.00
65.00	06500 RESPIRATORY THERAPY	0.000000	5,001,716	0	141,053	0	65.00
66.00	06600 PHYSICAL THERAPY	0.000000	1,601,775	0	29,423	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	1,314,391	0	6,465	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	686,072	0	163,124	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	3,969,148	0	6,384,047	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	262,348	0	1,070,400	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	8,550,864	0	6,225,064	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	2,260,164	0	3,577,299	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.009749	8,323,700	81,148	3,073,581	29,964	73.00
76.00	03630 ULTRA SOUND	0.000000	1,533,387	0	2,303,633	0	76.00
76.01	03951 PAIN CLINIC	0.000000	22,736	0	1,748,164	0	76.01
76.02	03952 CATH LAB	0.000000	6,486,892	0	13,687,738	0	76.02
76.03	03953 ACTIVITY THERAPEUTIC	0.000000	195,232	0	2,943	0	76.03
76.04	03954 WOUND CARE CENTER	0.000000	61,108	0	1,232,328	0	76.04
76.05	03340 BARIATRIC CLINIC	0.000000	652	0	292,801	0	76.05
76.06	03030 HEALTHY LIVING CENTER	0.000000	0	0	0	0	76.06
76.07	03950 CV RESOURCE CENTER	0.000000	0	0	0	0	76.07
76.08	03955 OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	0	0	76.08
76.09	03956 LACTATION CLINIC	0.000000	0	0	0	0	76.09
76.10	03957 OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	0	0	76.10
76.11	03958 OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	0	0	76.11
76.12	03959 ANTI COAGULATION CLINIC	0.000000	2,066	0	644,856	0	76.12
77.00	07700 ALLOGENEIC STEM CELL ACQUISITION	0.000000	0	0	0	0	77.00
78.00	07800 CAR T-CELL IMMUNOTHERAPY	0.000000	0	0	0	0	78.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
91.00	09100 EMERGENCY	0.001564	6,337,608	9,912	6,621,090	10,355	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000	1,440,353	0	908,134	0	92.00
200.00	Total (lines 50 through 199)		85,164,889	175,508	83,650,704	55,134	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 15-0090	Period: From 01/01/2023 To 12/31/2023	Worksheet D Part V Date/Time Prepared: 5/30/2024 3:45 pm				
		Title XVIII	Hospital	PPS				
Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs			
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)			
	1.00	2.00	3.00	4.00	5.00			
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	0.094675	8,995,236	0	0	851,624	50.00
50.01	05001	OUTPATIENT SURGERY	0.731590	408,750	0	0	299,037	50.01
51.00	05100	RECOVERY ROOM	0.085415	2,775,281	0	0	237,051	51.00
53.00	05300	ANESTHESIOLOGY	0.005160	1,873,138	0	0	9,665	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.086749	13,787,285	0	0	1,196,033	54.00
54.01	05401	RADIOLOGY-SPECIAL PROCEDURES	0.212871	2,044,530	0	0	435,221	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0.106524	3,425,150	0	0	364,861	56.00
60.00	06000	LABORATORY	0.138608	2,178,300	0	0	301,930	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.465175	50,891	0	0	23,673	63.00
65.00	06500	RESPIRATORY THERAPY	0.297511	141,053	0	0	41,965	65.00
66.00	06600	PHYSICAL THERAPY	0.251568	29,423	0	0	7,402	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.092473	6,465	0	0	598	67.00
68.00	06800	SPEECH PATHOLOGY	0.143394	163,124	0	0	23,391	68.00
69.00	06900	ELECTROCARDIOLOGY	0.081929	6,384,047	0	0	523,039	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.148449	1,070,400	0	0	158,900	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.327634	6,225,064	0	0	2,039,543	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.255306	3,577,299	0	0	913,306	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.276036	3,073,581	0	6,656	848,419	73.00
76.00	03630	ULTRA SOUND	0.100251	2,303,633	0	0	230,942	76.00
76.01	03951	PAIN CLINIC	0.229305	1,748,164	0	0	400,863	76.01
76.02	03952	CATH LAB	0.112006	13,687,738	0	0	1,533,109	76.02
76.03	03953	ACTIVITY THERAPEUTIC	1.002728	2,943	0	0	2,951	76.03
76.04	03954	WOUND CARE CENTER	0.359129	1,232,328	0	0	442,565	76.04
76.05	03340	BIOPATHY CLINIC	1.433676	292,801	0	0	419,782	76.05
76.06	03030	HEALTHY LIVING CENTER	0.000000	0	0	0	0	76.06
76.07	03950	CV RESOURCE CENTER	0.000000	0	0	0	0	76.07
76.08	03955	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	0	0	76.08
76.09	03956	LACTATION CLINIC	0.000000	0	0	0	0	76.09
76.10	03957	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	0	0	76.10
76.11	03958	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	0	0	76.11
76.12	03959	ANTICOAGULATION CLINIC	0.698569	644,856	0	0	450,476	76.12
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0.000000	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000	0	0	0	0	78.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
91.00	09100	EMERGENCY	0.168353	6,621,090	0	0	1,114,680	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.473742	908,134	0	0	430,221	92.00
200.00		Subtotal (see instructions)		83,650,704	0	6,656	13,301,247	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		83,650,704	0	6,656	13,301,247	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-0090	Period: From 01/01/2023 To 12/31/2023	Worksheet D Part V Date/Time Prepared: 5/30/2024 3:45 pm
	Title XVIII	Hospital	PPS

Cost Center Description	Costs		Hospital	PPS
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00 05000 OPERATING ROOM	0	0		50.00
50.01 05001 OUTPATIENT SURGERY	0	0		50.01
51.00 05100 RECOVERY ROOM	0	0		51.00
53.00 05300 ANESTHESIOLOGY	0	0		53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0		54.00
54.01 05401 RADIOLOGY-SPECIAL PROCEDURES	0	0		54.01
55.00 05500 RADIOLOGY-THERAPEUTIC	0	0		55.00
56.00 05600 RADIOISOTOPE	0	0		56.00
60.00 06000 LABORATORY	0	0		60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0		63.00
65.00 06500 RESPIRATORY THERAPY	0	0		65.00
66.00 06600 PHYSICAL THERAPY	0	0		66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0		67.00
68.00 06800 SPEECH PATHOLOGY	0	0		68.00
69.00 06900 ELECTROCARDIOLOGY	0	0		69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	1,837		73.00
76.00 03630 ULTRA SOUND	0	0		76.00
76.01 03951 PAIN CLINIC	0	0		76.01
76.02 03952 CATH LAB	0	0		76.02
76.03 03953 ACTIVITY THERAPEUTIC	0	0		76.03
76.04 03954 WOUND CARE CENTER	0	0		76.04
76.05 03340 BARIATRIC CLINIC	0	0		76.05
76.06 03030 HEALTHY LIVING CENTER	0	0		76.06
76.07 03950 CV RESOURCE CENTER	0	0		76.07
76.08 03955 OTHER ANCILLARY SERVICE COST CENTERS	0	0		76.08
76.09 03956 LACTATION CLINIC	0	0		76.09
76.10 03957 OTHER ANCILLARY SERVICE COST CENTERS	0	0		76.10
76.11 03958 OTHER ANCILLARY SERVICE COST CENTERS	0	0		76.11
76.12 03959 ANTICOAGULATION CLINIC	0	0		76.12
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	0	0		77.00
78.00 07800 CAR T-CELL IMMUNOTHERAPY	0	0		78.00
<b>OUTPATIENT SERVICE COST CENTERS</b>				
91.00 09100 EMERGENCY	0	0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
200.00 Subtotal (see instructions)	0	1,837		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00 Net Charges (line 200 - line 201)	0	1,837		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 15-0090 Component CCN: 15-T090		Period: From 01/01/2023 To 12/31/2023		Worksheet D Part II Date/Time Prepared: 5/30/2024 3:45 pm		
				Title XVIII		Subprovider - IRF		
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		
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	1,488,413	82,652,204	0.018008	114,296	2,058	50.00
50.01	05001	OUTPATIENT SURGERY	387,916	3,793,528	0.102257	9,089	929	50.01
51.00	05100	RECOVERY ROOM	190,545	16,151,657	0.011797	4,892	58	51.00
53.00	05300	ANESTHESIOLOGY	4,536	18,447,799	0.000246	9,158	2	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,746,011	88,287,475	0.019776	226,583	4,481	54.00
54.01	05401	RADIOLOGY-SPECIAL PROCEDURES	153,270	12,732,253	0.012038	51,280	617	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0.000000	0	0	55.00
56.00	05600	RADIOISOTOPE	221,609	10,679,671	0.020751	0	0	56.00
60.00	06000	LABORATORY	231,012	76,316,911	0.003027	474,416	1,436	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	72,108	1,567,708	0.045996	7,680	353	63.00
65.00	06500	RESPIRATORY THERAPY	182,615	13,697,800	0.013332	797,055	10,626	65.00
66.00	06600	PHYSICAL THERAPY	131,462	26,059,110	0.005045	2,051,229	10,348	66.00
67.00	06700	OCCUPATIONAL THERAPY	22,785	11,158,417	0.002042	1,906,691	3,893	67.00
68.00	06800	SPEECH PATHOLOGY	82,417	8,807,913	0.009357	881,297	8,246	68.00
69.00	06900	ELECTROCARDIOLOGY	311,116	26,818,703	0.011601	30,506	354	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	136,417	5,570,089	0.024491	13,055	320	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	108,143	52,969,791	0.002042	418,268	854	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	29,354	18,062,685	0.001625	4,979	8	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	169,941	39,660,597	0.004285	734,760	3,148	73.00
76.00	03630	ULTRA SOUND	165,937	13,649,936	0.012157	44,507	541	76.00
76.01	03951	PAIN CLINIC	329,781	9,751,124	0.033820	61	2	76.01
76.02	03952	CATH LAB	633,959	49,155,719	0.012897	52,456	677	76.02
76.03	03953	ACTIVITY THERAPEUTIC	161,666	3,118,083	0.051848	0	0	76.03
76.04	03954	WOUND CARE CENTER	171,114	4,342,175	0.039407	6,635	261	76.04
76.05	03340	BARIATRIC CLINIC	59,771	829,472	0.072059	49	4	76.05
76.06	03030	HEALTHY LIVING CENTER	0	0	0.000000	0	0	76.06
76.07	03950	CV RESOURCE CENTER	0	0	0.000000	0	0	76.07
76.08	03955	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0.000000	0	0	76.08
76.09	03956	LACTATION CLINIC	0	0	0.000000	0	0	76.09
76.10	03957	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0.000000	0	0	76.10
76.11	03958	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0.000000	0	0	76.11
76.12	03959	ANTI COAGULATION CLINIC	18,909	1,459,859	0.012953	0	0	76.12
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0.000000	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0.000000	0	0	78.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
91.00	09100	EMERGENCY	568,234	62,786,727	0.009050	8,839	80	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	9,303,915	0.000000	0	0	92.00
200.00		Total (lines 50 through 199)	7,779,041	667,831,321		7,847,781	49,296	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0090 Component CCN: 15-T090	Period: From 01/01/2023 To 12/31/2023	Worksheet D Part IV Date/Time Prepared: 5/30/2024 3:45 pm
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Title XVIII		Subprovider - IRF	PPS
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Cost Center Description		Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
		1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
50.01	05001	OUTPATIENT SURGERY	0	0	0	0	50.01
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
54.01	05401	RADIOLOGY-SPECIAL PROCEDURES	0	0	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	56.00
60.00	06000	LABORATORY	0	0	0	519,068	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	386,668	73.00
76.00	03630	ULTRA SOUND	0	0	0	0	76.00
76.01	03951	PAIN CLINIC	0	0	0	0	76.01
76.02	03952	CATH LAB	0	0	0	0	76.02
76.03	03953	ACTIVITY THERAPEUTIC	0	0	0	0	76.03
76.04	03954	WOUND CARE CENTER	0	0	0	0	76.04
76.05	03340	BARIATRIC CLINIC	0	0	0	0	76.05
76.06	03030	HEALTHY LIVING CENTER	0	0	0	0	76.06
76.07	03950	CV RESOURCE CENTER	0	0	0	0	76.07
76.08	03955	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	76.08
76.09	03956	LACTATION CLINIC	0	0	0	0	76.09
76.10	03957	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	76.10
76.11	03958	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	76.11
76.12	03959	ANTI COAGULATION CLINIC	0	0	0	0	76.12
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	0	0	0	98,228	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	92.00
200.00		Total (lines 50 through 199)	0	0	0	1,003,964	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0090 Component CCN: 15-T090	Period: From 01/01/2023 To 12/31/2023	Worksheet D Part IV Date/Time Prepared: 5/30/2024 3:45 pm
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	Title XVIII	Subprovider - IRF	PPS
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Cost Center Description	All Other Medical Education Cost	Total Cost (sum of col.s. 1, 2, 3, and 4)	Total Outpatient Cost (sum of col.s. 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	
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000 OPERATING ROOM	0	0	0	82,652,204	0.000000	50.00
50.01 05001 OUTPATIENT SURGERY	0	0	0	3,793,528	0.000000	50.01
51.00 05100 RECOVERY ROOM	0	0	0	16,151,657	0.000000	51.00
53.00 05300 ANESTHESIOLOGY	0	0	0	18,447,799	0.000000	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	0	88,287,475	0.000000	54.00
54.01 05401 RADIOLOGY-SPECIAL PROCEDURES	0	0	0	12,732,253	0.000000	54.01
55.00 05500 RADIOLOGY-THERAPEUTIC	0	0	0	0	0.000000	55.00
56.00 05600 RADIOISOTOPE	0	0	0	10,679,671	0.000000	56.00
60.00 06000 LABORATORY	0	519,068	519,068	76,316,911	0.006801	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	1,567,708	0.000000	63.00
65.00 06500 RESPIRATORY THERAPY	0	0	0	13,697,800	0.000000	65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	26,059,110	0.000000	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	11,158,417	0.000000	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0	8,807,913	0.000000	68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	0	26,818,703	0.000000	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	5,570,089	0.000000	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	52,969,791	0.000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	18,062,685	0.000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	386,668	386,668	39,660,597	0.009749	73.00
76.00 03630 ULTRASOUND	0	0	0	13,649,936	0.000000	76.00
76.01 03951 PAIN CLINIC	0	0	0	9,751,124	0.000000	76.01
76.02 03952 CATH LAB	0	0	0	49,155,719	0.000000	76.02
76.03 03953 ACTIVITY THERAPEUTIC	0	0	0	3,118,083	0.000000	76.03
76.04 03954 WOUND CARE CENTER	0	0	0	4,342,175	0.000000	76.04
76.05 03340 BARIATRIC CLINIC	0	0	0	829,472	0.000000	76.05
76.06 03030 HEALTHY LIVING CENTER	0	0	0	0	0.000000	76.06
76.07 03950 CV RESOURCE CENTER	0	0	0	0	0.000000	76.07
76.08 03955 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0.000000	76.08
76.09 03956 LACTATION CLINIC	0	0	0	0	0.000000	76.09
76.10 03957 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0.000000	76.10
76.11 03958 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0.000000	76.11
76.12 03959 ANTI COAGULATION CLINIC	0	0	0	1,459,859	0.000000	76.12
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0.000000	77.00
78.00 07800 CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0.000000	78.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
91.00 09100 EMERGENCY	0	98,228	98,228	62,786,727	0.001564	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	9,303,915	0.000000	92.00
200.00 Total (lines 50 through 199)	0	1,003,964	1,003,964	667,831,321		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 15-0090 Component CCN: 15-T090		Period: From 01/01/2023 To 12/31/2023		Worksheet D Part IV Date/Time Prepared: 5/30/2024 3:45 pm	
				Title XVIII		Subprovider - IRF	
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	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	0.000000	114,296	0	0	50.00
50.01	05001	OUTPATIENT SURGERY	0.000000	9,089	0	0	50.01
51.00	05100	RECOVERY ROOM	0.000000	4,892	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.000000	9,158	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	226,583	0	0	54.00
54.01	05401	RADIOLOGY-SPECIAL PROCEDURES	0.000000	51,280	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	56.00
60.00	06000	LABORATORY	0.006801	474,416	3,227	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	7,680	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.000000	797,055	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	2,051,229	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	1,906,691	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	881,297	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	30,506	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	13,055	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	418,268	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	4,979	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.009749	734,760	7,163	87	73.00
76.00	03630	ULTRA SOUND	0.000000	44,507	0	0	76.00
76.01	03951	PAIN CLINIC	0.000000	61	0	0	76.01
76.02	03952	CATH LAB	0.000000	52,456	0	0	76.02
76.03	03953	ACTIVITY THERAPEUTIC	0.000000	0	0	0	76.03
76.04	03954	WOUND CARE CENTER	0.000000	6,635	0	0	76.04
76.05	03340	BARIATRIC CLINIC	0.000000	49	0	0	76.05
76.06	03030	HEALTHY LIVING CENTER	0.000000	0	0	0	76.06
76.07	03950	CV RESOURCE CENTER	0.000000	0	0	0	76.07
76.08	03955	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	0	76.08
76.09	03956	LACTATION CLINIC	0.000000	0	0	0	76.09
76.10	03957	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	0	76.10
76.11	03958	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	0	76.11
76.12	03959	ANTI COAGULATION CLINIC	0.000000	0	0	0	76.12
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0.000000	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000	0	0	0	78.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
91.00	09100	EMERGENCY	0.001564	8,839	14	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	92.00
200.00		Total (lines 50 through 199)		7,847,781	10,404	87	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 15-0090 Component CCN: 15-T090	Period: From 01/01/2023 To 12/31/2023	Worksheet D Part V Date/Time Prepared: 5/30/2024 3:45 pm			
			Title XVIII	Subprovider - IRF	PPS		
Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs		
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)		
	1.00	2.00	3.00	4.00	5.00		
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	0.094675	0	0	0	50.00
50.01	05001	OUTPATIENT SURGERY	0.731590	0	0	0	50.01
51.00	05100	RECOVERY ROOM	0.085415	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.005160	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.086749	0	0	0	54.00
54.01	05401	RADIOLOGY-SPECIAL PROCEDURES	0.212871	0	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0.106524	0	0	0	56.00
60.00	06000	LABORATORY	0.138608	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.465175	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.297511	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.251568	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.092473	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.143394	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.081929	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.148449	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.327634	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.255306	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.276036	87	0	225	73.00
76.00	03630	ULTRA SOUND	0.100251	0	0	0	76.00
76.01	03951	PAIN CLINIC	0.229305	0	0	0	76.01
76.02	03952	CATH LAB	0.112006	0	0	0	76.02
76.03	03953	ACTIVITY THERAPEUTIC	1.002728	0	0	0	76.03
76.04	03954	WOUND CARE CENTER	0.359129	0	0	0	76.04
76.05	03340	BARIATRIC CLINIC	1.433676	0	0	0	76.05
76.06	03030	HEALTHY LIVING CENTER	0.000000	0	0	0	76.06
76.07	03950	CV RESOURCE CENTER	0.000000	0	0	0	76.07
76.08	03955	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	0	76.08
76.09	03956	LACTATION CLINIC	0.000000	0	0	0	76.09
76.10	03957	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	0	76.10
76.11	03958	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	0	76.11
76.12	03959	ANTI COAGULATION CLINIC	0.698569	0	0	0	76.12
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0.000000	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000	0	0	0	78.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
91.00	09100	EMERGENCY	0.168353	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.473742	0	0	0	92.00
200.00		Subtotal (see instructions)		87	0	225	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0	201.00
202.00		Net Charges (line 200 - line 201)		87	0	225	202.00



APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-0090 Component CCN: 15-T090	Period: From 01/01/2023 To 12/31/2023	Worksheet D Part V Date/Time Prepared: 5/30/2024 3:45 pm
	Title XVIII	Subprovider - IRF	PPS

Cost Center Description	Costs		
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
	6.00	7.00	
<b>ANCILLARY SERVICE COST CENTERS</b>			
50.00 05000 OPERATING ROOM	0	0	50.00
50.01 05001 OUTPATIENT SURGERY	0	0	50.01
51.00 05100 RECOVERY ROOM	0	0	51.00
53.00 05300 ANESTHESIOLOGY	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	54.00
54.01 05401 RADIOLOGY-SPECIAL PROCEDURES	0	0	54.01
55.00 05500 RADIOLOGY-THERAPEUTIC	0	0	55.00
56.00 05600 RADIOISOTOPE	0	0	56.00
60.00 06000 LABORATORY	0	0	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	63.00
65.00 06500 RESPIRATORY THERAPY	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	62	73.00
76.00 03630 ULTRA SOUND	0	0	76.00
76.01 03951 PAIN CLINIC	0	0	76.01
76.02 03952 CATH LAB	0	0	76.02
76.03 03953 ACTIVITY THERAPEUTIC	0	0	76.03
76.04 03954 WOUND CARE CENTER	0	0	76.04
76.05 03340 BARIATRIC CLINIC	0	0	76.05
76.06 03030 HEALTHY LIVING CENTER	0	0	76.06
76.07 03950 CV RESOURCE CENTER	0	0	76.07
76.08 03955 OTHER ANCILLARY SERVICE COST CENTERS	0	0	76.08
76.09 03956 LACTATION CLINIC	0	0	76.09
76.10 03957 OTHER ANCILLARY SERVICE COST CENTERS	0	0	76.10
76.11 03958 OTHER ANCILLARY SERVICE COST CENTERS	0	0	76.11
76.12 03959 ANTI COAGULATION CLINIC	0	0	76.12
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	0	0	77.00
78.00 07800 CAR T-CELL IMMUNOTHERAPY	0	0	78.00
<b>OUTPATIENT SERVICE COST CENTERS</b>			
91.00 09100 EMERGENCY	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
200.00 Subtotal (see instructions)	0	62	200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00 Net Charges (line 200 - line 201)	0	62	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-0090	Period: From 01/01/2023 To 12/31/2023	Worksheet D Part V Date/Time Prepared: 5/30/2024 3:45 pm
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Cost Center Description		Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges	Costs			
			PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)			
		1.00	2.00	3.00			
			4.00	5.00			
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	0.094675	0	8,757,373	0	0	50.00
50.01	05001 OUTPATIENT SURGERY	0.731590	0	665,555	0	0	50.01
51.00	05100 RECOVERY ROOM	0.085415	0	2,398,436	0	0	51.00
53.00	05300 ANESTHESIOLOGY	0.005160	0	2,636,448	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.086749	0	12,668,105	0	0	54.00
54.01	05401 RADIOLOGY-SPECIAL PROCEDURES	0.212871	0	773,325	0	0	54.01
55.00	05500 RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	0	55.00
56.00	05600 RADIOISOTOPE	0.106524	0	659,444	0	0	56.00
60.00	06000 LABORATORY	0.138608	0	9,450,108	0	0	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.465175	0	111,188	0	0	63.00
65.00	06500 RESPIRATORY THERAPY	0.297511	0	251,265	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.251568	0	2,490,472	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.092473	0	1,468,128	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.143394	0	1,662,162	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.081929	0	1,800,245	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.148449	0	727,143	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.327634	0	5,480,891	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.255306	0	687,053	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.276036	0	1,814,791	0	0	73.00
76.00	03630 ULTRA SOUND	0.100251	0	1,695,456	0	0	76.00
76.01	03951 PAIN CLINIC	0.229305	0	1,642,000	0	0	76.01
76.02	03952 CATH LAB	0.112006	0	1,185,837	0	0	76.02
76.03	03953 ACTIVITY THERAPEUTIC	1.002728	0	84,497	0	0	76.03
76.04	03954 WOUND CARE CENTER	0.359129	0	518,113	0	0	76.04
76.05	03340 BARIATRIC CLINIC	1.433676	0	201,640	0	0	76.05
76.06	03030 HEALTHY LIVING CENTER	0.000000	0	0	0	0	76.06
76.07	03950 CV RESOURCE CENTER	0.000000	0	0	0	0	76.07
76.08	03955 OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	0	0	76.08
76.09	03956 LACTATION CLINIC	0.000000	0	0	0	0	76.09
76.10	03957 OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	0	0	76.10
76.11	03958 OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	0	0	76.11
76.12	03959 ANTICOAGULATION CLINIC	0.698569	0	100,440	0	0	76.12
77.00	07700 ALLOGENEIC STEM CELL ACQUISITION	0.000000	0	0	0	0	77.00
78.00	07800 CAR T-CELL IMMUNOTHERAPY	0.000000	0	0	0	0	78.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
91.00	09100 EMERGENCY	0.168353	0	17,478,454	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.473742	0	1,666,602	0	0	92.00
200.00	Subtotal (see instructions)		0	79,075,171	0	0	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0	0	201.00
202.00	Net Charges (line 200 - line 201)		0	79,075,171	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-0090	Period: From 01/01/2023 To 12/31/2023	Worksheet D Part V Date/Time Prepared: 5/30/2024 3:45 pm
	Title XIX	Hospital	Cost

Cost Center Description	Costs		Hospital	Cost
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00 05000 OPERATING ROOM	829,104	0		50.00
50.01 05001 OUTPATIENT SURGERY	486,913	0		50.01
51.00 05100 RECOVERY ROOM	204,862	0		51.00
53.00 05300 ANESTHESIOLOGY	13,604	0		53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	1,098,945	0		54.00
54.01 05401 RADIOLOGY-SPECIAL PROCEDURES	164,618	0		54.01
55.00 05500 RADIOLOGY-THERAPEUTIC	0	0		55.00
56.00 05600 RADIOISOTOPE	70,247	0		56.00
60.00 06000 LABORATORY	1,309,861	0		60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	51,722	0		63.00
65.00 06500 RESPIRATORY THERAPY	74,754	0		65.00
66.00 06600 PHYSICAL THERAPY	626,523	0		66.00
67.00 06700 OCCUPATIONAL THERAPY	135,762	0		67.00
68.00 06800 SPEECH PATHOLOGY	238,344	0		68.00
69.00 06900 ELECTROCARDIOLOGY	147,492	0		69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	107,944	0		70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1,795,726	0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	175,409	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	500,948	0		73.00
76.00 03630 ULTRA SOUND	169,971	0		76.00
76.01 03951 PAIN CLINIC	376,519	0		76.01
76.02 03952 CATH LAB	132,821	0		76.02
76.03 03953 ACTIVITY THERAPEUTIC	84,728	0		76.03
76.04 03954 WOUND CARE CENTER	186,069	0		76.04
76.05 03340 BARIATRIC CLINIC	289,086	0		76.05
76.06 03030 HEALTHY LIVING CENTER	0	0		76.06
76.07 03950 CV RESOURCE CENTER	0	0		76.07
76.08 03955 OTHER ANCILLARY SERVICE COST CENTERS	0	0		76.08
76.09 03956 LACTATION CLINIC	0	0		76.09
76.10 03957 OTHER ANCILLARY SERVICE COST CENTERS	0	0		76.10
76.11 03958 OTHER ANCILLARY SERVICE COST CENTERS	0	0		76.11
76.12 03959 ANTICOAGULATION CLINIC	70,164	0		76.12
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	0	0		77.00
78.00 07800 CAR T-CELL IMMUNOTHERAPY	0	0		78.00
<b>OUTPATIENT SERVICE COST CENTERS</b>				
91.00 09100 EMERGENCY	2,942,550	0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	789,539	0		92.00
200.00 Subtotal (see instructions)	13,074,225	0		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00 Net Charges (line 200 - line 201)	13,074,225	0		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 15-0090 Component CCN: 15-T090		Period: From 01/01/2023 To 12/31/2023		Worksheet D Part II Date/Time Prepared: 5/30/2024 3:45 pm	
		Title XIX		Subprovider - IRF		TEFRA	
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	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	1,488,413	82,652,204	0.018008	0	0 50.00
50.01	05001	OUTPATIENT SURGERY	387,916	3,793,528	0.102257	0	0 50.01
51.00	05100	RECOVERY ROOM	190,545	16,151,657	0.011797	0	0 51.00
53.00	05300	ANESTHESIOLOGY	4,536	18,447,799	0.000246	0	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,746,011	88,287,475	0.019776	0	0 54.00
54.01	05401	RADIOLOGY-SPECIAL PROCEDURES	153,270	12,732,253	0.012038	0	0 54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0.000000	0	0 55.00
56.00	05600	RADIOISOTOPE	221,609	10,679,671	0.020751	0	0 56.00
60.00	06000	LABORATORY	231,012	76,316,911	0.003027	792	2 60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	72,108	1,567,708	0.045996	0	0 63.00
65.00	06500	RESPIRATORY THERAPY	182,615	13,697,800	0.013332	0	0 65.00
66.00	06600	PHYSICAL THERAPY	131,462	26,059,110	0.005045	0	0 66.00
67.00	06700	OCCUPATIONAL THERAPY	22,785	11,158,417	0.002042	0	0 67.00
68.00	06800	SPEECH PATHOLOGY	82,417	8,807,913	0.009357	0	0 68.00
69.00	06900	ELECTROCARDIOLOGY	311,116	26,818,703	0.011601	0	0 69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	136,417	5,570,089	0.024491	0	0 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	108,143	52,969,791	0.002042	0	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	29,354	18,062,685	0.001625	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	169,941	39,660,597	0.004285	0	0 73.00
76.00	03630	ULTRA SOUND	165,937	13,649,936	0.012157	0	0 76.00
76.01	03951	PAIN CLINIC	329,781	9,751,124	0.033820	0	0 76.01
76.02	03952	CATH LAB	633,959	49,155,719	0.012897	0	0 76.02
76.03	03953	ACTIVITY THERAPEUTIC	161,666	3,118,083	0.051848	0	0 76.03
76.04	03954	WOUND CARE CENTER	171,114	4,342,175	0.039407	0	0 76.04
76.05	03340	BARIATRIC CLINIC	59,771	829,472	0.072059	0	0 76.05
76.06	03030	HEALTHY LIVING CENTER	0	0	0.000000	0	0 76.06
76.07	03950	CV RESOURCE CENTER	0	0	0.000000	0	0 76.07
76.08	03955	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0.000000	0	0 76.08
76.09	03956	LACTATION CLINIC	0	0	0.000000	0	0 76.09
76.10	03957	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0.000000	0	0 76.10
76.11	03958	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0.000000	0	0 76.11
76.12	03959	ANTI COAGULATION CLINIC	18,909	1,459,859	0.012953	0	0 76.12
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0.000000	0	0 77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0.000000	0	0 78.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
91.00	09100	EMERGENCY	568,234	62,786,727	0.009050	0	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	9,303,915	0.000000	0	0 92.00
200.00		Total (lines 50 through 199)	7,779,041	667,831,321		792	2,200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0090 Component CCN: 15-T090	Period: From 01/01/2023 To 12/31/2023	Worksheet D Part IV Date/Time Prepared: 5/30/2024 3:45 pm
	Title XIX	Subprovider - IRF	TEFRA

Cost Center Description		Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
		1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
50.01	05001	OUTPATIENT SURGERY	0	0	0	0	50.01
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
54.01	05401	RADIOLOGY-SPECIAL PROCEDURES	0	0	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	56.00
60.00	06000	LABORATORY	0	0	0	519,068	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	386,668	73.00
76.00	03630	ULTRA SOUND	0	0	0	0	76.00
76.01	03951	PAIN CLINIC	0	0	0	0	76.01
76.02	03952	CATH LAB	0	0	0	0	76.02
76.03	03953	ACTIVITY THERAPEUTIC	0	0	0	0	76.03
76.04	03954	WOUND CARE CENTER	0	0	0	0	76.04
76.05	03340	BARIATRIC CLINIC	0	0	0	0	76.05
76.06	03030	HEALTHY LIVING CENTER	0	0	0	0	76.06
76.07	03950	CV RESOURCE CENTER	0	0	0	0	76.07
76.08	03955	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	76.08
76.09	03956	LACTATION CLINIC	0	0	0	0	76.09
76.10	03957	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	76.10
76.11	03958	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	76.11
76.12	03959	ANTI COAGULATION CLINIC	0	0	0	0	76.12
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	0	0	0	98,228	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	92.00
200.00		Total (lines 50 through 199)	0	0	0	1,003,964	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0090 Component CCN: 15-T090	Period: From 01/01/2023 To 12/31/2023	Worksheet D Part IV Date/Time Prepared: 5/30/2024 3:45 pm
	Title XIX	Subprovider - IRF	TEFRA

Cost Center Description	All Other Medical Education Cost	Total Cost (sum of col.s. 1, 2, 3, and 4)	Total Outpatient Cost (sum of col.s. 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	
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000 OPERATING ROOM	0	0	0	82,652,204	0.000000	50.00
50.01 05001 OUTPATIENT SURGERY	0	0	0	3,793,528	0.000000	50.01
51.00 05100 RECOVERY ROOM	0	0	0	16,151,657	0.000000	51.00
53.00 05300 ANESTHESIOLOGY	0	0	0	18,447,799	0.000000	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	0	88,287,475	0.000000	54.00
54.01 05401 RADIOLOGY-SPECIAL PROCEDURES	0	0	0	12,732,253	0.000000	54.01
55.00 05500 RADIOLOGY-THERAPEUTIC	0	0	0	0	0.000000	55.00
56.00 05600 RADIOISOTOPE	0	0	0	10,679,671	0.000000	56.00
60.00 06000 LABORATORY	0	519,068	519,068	76,316,911	0.006801	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	1,567,708	0.000000	63.00
65.00 06500 RESPIRATORY THERAPY	0	0	0	13,697,800	0.000000	65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	26,059,110	0.000000	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	11,158,417	0.000000	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0	8,807,913	0.000000	68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	0	26,818,703	0.000000	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	5,570,089	0.000000	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	52,969,791	0.000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	18,062,685	0.000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	386,668	386,668	39,660,597	0.009749	73.00
76.00 03630 ULTRASOUND	0	0	0	13,649,936	0.000000	76.00
76.01 03951 PAIN CLINIC	0	0	0	9,751,124	0.000000	76.01
76.02 03952 CATH LAB	0	0	0	49,155,719	0.000000	76.02
76.03 03953 ACTIVITY THERAPEUTIC	0	0	0	3,118,083	0.000000	76.03
76.04 03954 WOUND CARE CENTER	0	0	0	4,342,175	0.000000	76.04
76.05 03340 BARIATRIC CLINIC	0	0	0	829,472	0.000000	76.05
76.06 03030 HEALTHY LIVING CENTER	0	0	0	0	0.000000	76.06
76.07 03950 CV RESOURCE CENTER	0	0	0	0	0.000000	76.07
76.08 03955 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0.000000	76.08
76.09 03956 LACTATION CLINIC	0	0	0	0	0.000000	76.09
76.10 03957 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0.000000	76.10
76.11 03958 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0.000000	76.11
76.12 03959 ANTI COAGULATION CLINIC	0	0	0	1,459,859	0.000000	76.12
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0.000000	77.00
78.00 07800 CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0.000000	78.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
91.00 09100 EMERGENCY	0	98,228	98,228	62,786,727	0.001564	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	9,303,915	0.000000	92.00
200.00 Total (lines 50 through 199)	0	1,003,964	1,003,964	667,831,321		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0090 Component CCN: 15-T090	Period: From 01/01/2023 To 12/31/2023	Worksheet D Part IV Date/Time Prepared: 5/30/2024 3:45 pm
	Title XIX	Subprovider - IRF	TEFRA

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	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	0.000000	0	0	0	0	50.00
50.01	05001 OUTPATIENT SURGERY	0.000000	0	0	0	0	50.01
51.00	05100 RECOVERY ROOM	0.000000	0	0	0	0	51.00
53.00	05300 ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000	0	0	0	0	54.00
54.01	05401 RADIOLOGY-SPECIAL PROCEDURES	0.000000	0	0	0	0	54.01
55.00	05500 RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	0	55.00
56.00	05600 RADIOISOTOPE	0.000000	0	0	0	0	56.00
60.00	06000 LABORATORY	0.006801	792	5	0	0	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	0	0	63.00
65.00	06500 RESPIRATORY THERAPY	0.000000	0	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.000000	0	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.009749	0	0	0	0	73.00
76.00	03630 ULTRA SOUND	0.000000	0	0	0	0	76.00
76.01	03951 PAIN CLINIC	0.000000	0	0	0	0	76.01
76.02	03952 CATH LAB	0.000000	0	0	0	0	76.02
76.03	03953 ACTIVITY THERAPEUTIC	0.000000	0	0	0	0	76.03
76.04	03954 WOUND CARE CENTER	0.000000	0	0	0	0	76.04
76.05	03340 BARIATRIC CLINIC	0.000000	0	0	0	0	76.05
76.06	03030 HEALTHY LIVING CENTER	0.000000	0	0	0	0	76.06
76.07	03950 CV RESOURCE CENTER	0.000000	0	0	0	0	76.07
76.08	03955 OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	0	0	76.08
76.09	03956 LACTATION CLINIC	0.000000	0	0	0	0	76.09
76.10	03957 OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	0	0	76.10
76.11	03958 OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	0	0	76.11
76.12	03959 ANTI COAGULATION CLINIC	0.000000	0	0	0	0	76.12
77.00	07700 ALLOGENEIC STEM CELL ACQUISITION	0.000000	0	0	0	0	77.00
78.00	07800 CAR T-CELL IMMUNOTHERAPY	0.000000	0	0	0	0	78.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
91.00	09100 EMERGENCY	0.001564	0	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
200.00	Total (lines 50 through 199)		792	5	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-0090 Component CCN: 15-T090	Period: From 01/01/2023 To 12/31/2023	Worksheet D Part V Date/Time Prepared: 5/30/2024 3:45 pm
	Title XIX	Subprovider - IRF	TEFRA

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			PPS Services (see inst.)	Costs (see inst.)
		Cost Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000 OPERATING ROOM	0.094675	0	0	0	0	50.00
50.01 05001 OUTPATIENT SURGERY	0.731590	0	0	0	0	50.01
51.00 05100 RECOVERY ROOM	0.085415	0	0	0	0	51.00
53.00 05300 ANESTHESIOLOGY	0.005160	0	0	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.086749	0	0	0	0	54.00
54.01 05401 RADIOLOGY-SPECIAL PROCEDURES	0.212871	0	0	0	0	54.01
55.00 05500 RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	0	55.00
56.00 05600 RADIOISOTOPE	0.106524	0	0	0	0	56.00
60.00 06000 LABORATORY	0.138608	0	0	0	0	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0.465175	0	0	0	0	63.00
65.00 06500 RESPIRATORY THERAPY	0.297511	0	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0.251568	0	0	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0.092473	0	0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0.143394	0	0	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0.081929	0	0	0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0.148449	0	0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.327634	0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.255306	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0.276036	0	0	0	0	73.00
76.00 03630 ULTRA SOUND	0.100251	0	0	0	0	76.00
76.01 03951 PAIN CLINIC	0.229305	0	0	0	0	76.01
76.02 03952 CATH LAB	0.112006	0	0	0	0	76.02
76.03 03953 ACTIVITY THERAPEUTIC	1.002728	0	0	0	0	76.03
76.04 03954 WOUND CARE CENTER	0.359129	0	0	0	0	76.04
76.05 03340 BARIATRIC CLINIC	1.433676	0	0	0	0	76.05
76.06 03030 HEALTHY LIVING CENTER	0.000000	0	0	0	0	76.06
76.07 03950 CV RESOURCE CENTER	0.000000	0	0	0	0	76.07
76.08 03955 OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	0	0	76.08
76.09 03956 LACTATION CLINIC	0.000000	0	0	0	0	76.09
76.10 03957 OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	0	0	76.10
76.11 03958 OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	0	0	76.11
76.12 03959 ANTI COAGULATION CLINIC	0.698569	0	0	0	0	76.12
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	0.000000	0	0	0	0	77.00
78.00 07800 CAR T-CELL IMMUNOTHERAPY	0.000000	0	0	0	0	78.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
91.00 09100 EMERGENCY	0.168353	0	0	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0.473742	0	0	0	0	92.00
200.00	Subtotal (see instructions)	0	0	0	0	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges		0	0	0	201.00
202.00	Net Charges (line 200 - line 201)		0	0	0	202.00



APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-0090 Component CCN: 15-T090	Period: From 01/01/2023 To 12/31/2023	Worksheet D Part V Date/Time Prepared: 5/30/2024 3:45 pm
	Title XIX	Subprovider - IRF	TEFRA

Cost Center Description	Costs		
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
	6.00	7.00	
<b>ANCILLARY SERVICE COST CENTERS</b>			
50.00 05000 OPERATING ROOM	0	0	50.00
50.01 05001 OUTPATIENT SURGERY	0	0	50.01
51.00 05100 RECOVERY ROOM	0	0	51.00
53.00 05300 ANESTHESIOLOGY	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	54.00
54.01 05401 RADIOLOGY-SPECIAL PROCEDURES	0	0	54.01
55.00 05500 RADIOLOGY-THERAPEUTIC	0	0	55.00
56.00 05600 RADIOISOTOPE	0	0	56.00
60.00 06000 LABORATORY	0	0	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	63.00
65.00 06500 RESPIRATORY THERAPY	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	73.00
76.00 03630 ULTRA SOUND	0	0	76.00
76.01 03951 PAIN CLINIC	0	0	76.01
76.02 03952 CATH LAB	0	0	76.02
76.03 03953 ACTIVITY THERAPEUTIC	0	0	76.03
76.04 03954 WOUND CARE CENTER	0	0	76.04
76.05 03340 BARIATRIC CLINIC	0	0	76.05
76.06 03030 HEALTHY LIVING CENTER	0	0	76.06
76.07 03950 CV RESOURCE CENTER	0	0	76.07
76.08 03955 OTHER ANCILLARY SERVICE COST CENTERS	0	0	76.08
76.09 03956 LACTATION CLINIC	0	0	76.09
76.10 03957 OTHER ANCILLARY SERVICE COST CENTERS	0	0	76.10
76.11 03958 OTHER ANCILLARY SERVICE COST CENTERS	0	0	76.11
76.12 03959 ANTI COAGULATION CLINIC	0	0	76.12
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	0	0	77.00
78.00 07800 CAR T-CELL IMMUNOTHERAPY	0	0	78.00
<b>OUTPATIENT SERVICE COST CENTERS</b>			
91.00 09100 EMERGENCY	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
200.00 Subtotal (see instructions)	0	0	200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00 Net Charges (line 200 - line 201)	0	0	202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0090	Period: From 01/01/2023 To 12/31/2023	Worksheet D-1
		Title XVIII	Hospital	Date/Time Prepared: 5/30/2024 3:45 pm
Cost Center Description				PPS
				1.00
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		27,557	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		27,557	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)		24,760	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)		7,090	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
<b>SWING BED ADJUSTMENT</b>				
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)		43,425,611	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)		43,425,611	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
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)		27 43,425,611	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,575.85	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		11,172,777	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		11,172,777	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0090		Period: From 01/01/2023 To 12/31/2023		Worksheet D-1	
		Title XVIII		Hospital		PPS	
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	6,001,644	2,392	2,509.05	837	2,100,075	43.00
44.00	CORONARY CARE UNIT	0	0	0.00	0	0	44.00
45.00	BURN INTENSIVE CARE UNIT	0	0	0.00	0	0	45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	NEONATAL INTENSIVE CARE UNIT	1,221,017	350	3,488.62	0	0	47.00
Cost Center Description							
						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					15,660,439	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)					28,933,291	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)					820,476	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					1,119,651	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					1,940,127	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthesiologist, and medical education costs (line 49 minus line 52)					26,993,164	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
55.01	Permanent adjustment amount per discharge					0.00	55.01
55.02	Adjustment amount per discharge (contractor use only)					0.00	55.02
56.00	Target amount (line 54 x sum of lines 55, 55.01, and 55.02)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)					0.00	59.00
60.00	Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)					0.00	60.00
61.00	Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					2,797	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,575.85	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					4,407,652	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0090		Period: From 01/01/2023 To 12/31/2023		Worksheet D-1 Date/Time Prepared: 5/30/2024 3:45 pm	
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	2,671,724	43,425,611	0.061524	4,407,652	271,176	90.00
91.00	Nursing Program cost	0	43,425,611	0.000000	4,407,652	0	91.00
92.00	Allied health cost	0	43,425,611	0.000000	4,407,652	0	92.00
93.00	All other Medical Education	0	43,425,611	0.000000	4,407,652	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0090 Component CCN: 15-T090	Period: From 01/01/2023 To 12/31/2023	Worksheet D-1 Date/Time Prepared: 5/30/2024 3:45 pm
		Title XVIII	Subprovider - IRF	PPS
Cost Center Description				1.00
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			3,964 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			3,964 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)			3,964 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)			2,694 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
<b>SWING BED ADJUSTMENT</b>				
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)			4,555,491 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)			4,555,491 27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
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)			4,555,491 37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)			1,149.22 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			3,095,999 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)			3,095,999 41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0090		Period: From 01/01/2023 To 12/31/2023		Worksheet D-1	
		Component CCN: 15-T090				Date/Time Prepared: 5/30/2024 3:45 pm	
		Title XVIII		Subprovider - IRF		PPS	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0	0	42.00
<b>Intensive Care Type Inpatient Hospital Units</b>							
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	0	0	43.00
44.00 CORONARY CARE UNIT	0	0	0.00	0	0	0	44.00
45.00 BURN INTENSIVE CARE UNIT	0	0	0.00	0	0	0	45.00
46.00 SURGICAL INTENSIVE CARE UNIT							46.00
47.00 NEONATAL INTENSIVE CARE UNIT	0	0	0.00	0	0	0	47.00
<b>Cost Center Description</b>							
					1.00		
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					1,533,544		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)					4,629,543		49.00
<b>PASS THROUGH COST ADJUSTMENTS</b>							
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					144,910		50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					59,700		51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					204,610		52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					4,424,933		53.00
<b>TARGET AMOUNT AND LIMIT COMPUTATION</b>							
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
<b>PROGRAM INPATIENT ROUTINE SWING BED COST</b>							
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
<b>PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY</b>							
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
<b>PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST</b>							
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

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0090 Component CCN: 15-T090	Period: From 01/01/2023 To 12/31/2023	Worksheet D-1 Date/Time Prepared: 5/30/2024 3:45 pm
	Title XVIII	Subprovider - IRF	PPS

Cost Center Description						1.00	
89.00	Observation bed cost (line 87 x line 88) (see instructions)					0	89.00
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	213,206	4,555,491	0.046802	0	0	90.00
91.00	Nursing Program cost	0	4,555,491	0.000000	0	0	91.00
92.00	Allied health cost	0	4,555,491	0.000000	0	0	92.00
93.00	All other Medical Education	0	4,555,491	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0090	Period: From 01/01/2023 To 12/31/2023	Worksheet D-1 Date/Time Prepared: 5/30/2024 3:45 pm
Cost Center Description		Title XIX	Hospital	Cost
				1.00
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			27,557 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			27,557 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)			24,760 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)			303 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)			704 15.00
16.00	Nursery days (title V or XIX only)			558 16.00
<b>SWING BED ADJUSTMENT</b>				
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)			43,425,611 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)			43,425,611 27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
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)			27 43,425,611 37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)			1,575.85 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			477,483 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)			477,483 41.00



COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0090		Period: From 01/01/2023 To 12/31/2023		Worksheet D-1	
		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)	1,784,715	704	2,535.11	558	1,414,591	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	6,001,644	2,392	2,509.05	1,044	2,619,448	43.00
44.00	CORONARY CARE UNIT	0	0	0.00	0	0	44.00
45.00	BURN INTENSIVE CARE UNIT	0	0	0.00	0	0	45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	NEONATAL INTENSIVE CARE UNIT	1,221,017	350	3,488.62	305	1,064,029	47.00
Cost Center Description							
						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					8,525,335	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)					14,100,886	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)					2,797	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,575.85	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					4,407,652	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0090		Period: From 01/01/2023 To 12/31/2023		Worksheet D-1 Date/Time Prepared: 5/30/2024 3:45 pm	
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	2,671,724	43,425,611	0.061524	4,407,652	271,176	90.00
91.00	Nursing Program cost	0	43,425,611	0.000000	4,407,652	0	91.00
92.00	Allied health cost	0	43,425,611	0.000000	4,407,652	0	92.00
93.00	All other Medical Education	0	43,425,611	0.000000	4,407,652	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0090 Component CCN: 15-T090	Period: From 01/01/2023 To 12/31/2023	Worksheet D-1 Date/Time Prepared: 5/30/2024 3:45 pm
		Title XIX	Subprovider - IRF	TEFRA
Cost Center Description				1.00
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			3,964 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			3,964 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)			3,964 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)			16 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)			704 15.00
16.00	Nursery days (title V or XIX only)			558 16.00
<b>SWING BED ADJUSTMENT</b>				
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)			4,555,491 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)			4,555,491 27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
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)			4,555,491 37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)			1,149.22 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			18,388 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)			18,388 41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0090		Period: From 01/01/2023 To 12/31/2023		Worksheet D-1	
		Component CCN: 15-T090				Date/Time Prepared: 5/30/2024 3:45 pm	
		Title XIX		Subprovider - IRF		TEFRA	
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
<b>Intensive Care Type Inpatient Hospital Units</b>							
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT	0	0	0.00	0	0	44.00
45.00	BURN INTENSIVE CARE UNIT	0	0	0.00	0	0	45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	NEONATAL INTENSIVE CARE UNIT	0	0	0.00	0	0	47.00
<b>Cost Center Description</b>						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					110	48.00
48.01	Program inpatient cellular therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1)					0	48.01
49.00	Total Program inpatient costs (sum of lines 41 through 48.01)(see instructions)					18,498	49.00
<b>PASS THROUGH COST ADJUSTMENTS</b>							
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)					7	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					7	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					18,491	53.00
<b>TARGET AMOUNT AND LIMIT COMPUTATION</b>							
54.00	Program discharges					8	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)					-18,491	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)					7	63.00
<b>PROGRAM INPATIENT ROUTINE SWING BED COST</b>							
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
<b>PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY</b>							
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
<b>PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST</b>							
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

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0090 Component CCN: 15-T090	Period: From 01/01/2023 To 12/31/2023	Worksheet D-1 Date/Time Prepared: 5/30/2024 3:45 pm
	Title XIX	Subprovider - IRF	TEFRA

Cost Center Description						1.00	
89.00	Observation bed cost (line 87 x line 88) (see instructions)					0	89.00
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	0	4,555,491	0.000000	0	0	90.00
91.00	Nursing Program cost	0	4,555,491	0.000000	0	0	91.00
92.00	Allied health cost	0	4,555,491	0.000000	0	0	92.00
93.00	All other Medical Education	0	4,555,491	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0090	Period: From 01/01/2023 To 12/31/2023	Worksheet D-3 Date/Time Prepared: 5/30/2024 3:45 pm	
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	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS		16,043,792	30.00
31.00	03100	INTENSIVE CARE UNIT		3,710,757	31.00
32.00	03200	CORONARY CARE UNIT		0	32.00
33.00	03300	BURN INTENSIVE CARE UNIT		0	33.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT		0	35.00
41.00	04100	SUBPROVIDER - I RF		0	41.00
42.00	04200	SUBPROVIDER		0	42.00
43.00	04300	NURSERY			43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	0.094675	7,929,978	750,771 50.00
50.01	05001	OUTPATIENT SURGERY	0.731590	781,145	571,478 50.01
51.00	05100	RECOVERY ROOM	0.085415	769,528	65,729 51.00
53.00	05300	ANESTHESIOLOGY	0.005160	1,735,368	8,954 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.086749	10,919,638	947,268 54.00
54.01	05401	RADIOLOGY-SPECIAL PROCEDURES	0.212871	1,551,649	330,301 54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0 55.00
56.00	05600	RADIOISOTOPE	0.106524	589,328	62,778 56.00
60.00	06000	LABORATORY	0.138608	12,417,029	1,721,100 60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.465175	421,014	195,845 63.00
65.00	06500	RESPIRATORY THERAPY	0.297511	5,001,716	1,488,066 65.00
66.00	06600	PHYSICAL THERAPY	0.251568	1,601,775	402,955 66.00
67.00	06700	OCCUPATIONAL THERAPY	0.092473	1,314,391	121,546 67.00
68.00	06800	SPEECH PATHOLOGY	0.143394	686,072	98,379 68.00
69.00	06900	ELECTROCARDIOLOGY	0.081929	3,969,148	325,188 69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.148449	262,348	38,945 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.327634	8,550,864	2,801,554 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.255306	2,260,164	577,033 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.276036	8,323,700	2,297,641 73.00
76.00	03630	ULTRA SOUND	0.100251	1,533,387	153,724 76.00
76.01	03951	PAIN CLINIC	0.229305	22,736	5,213 76.01
76.02	03952	CATH LAB	0.112006	6,486,892	726,571 76.02
76.03	03953	ACTIVITY THERAPEUTIC	1.002728	195,232	195,765 76.03
76.04	03954	WOUND CARE CENTER	0.359129	61,108	21,946 76.04
76.05	03340	BARIATRIC CLINIC	1.433676	652	935 76.05
76.06	03030	HEALTHY LIVING CENTER	0.000000	0	0 76.06
76.07	03950	CV RESOURCE CENTER	0.000000	0	0 76.07
76.08	03955	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0 76.08
76.09	03956	LACTATION CLINIC	0.000000	0	0 76.09
76.10	03957	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0 76.10
76.11	03958	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0 76.11
76.12	03959	ANTI COAGULATION CLINIC	0.698569	2,066	1,443 76.12
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0.000000	0	0 77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000	0	0 78.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
91.00	09100	EMERGENCY	0.168353	6,337,608	1,066,955 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.473742	1,440,353	682,356 92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		85,164,889	15,660,439 200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0 201.00
202.00		Net charges (line 200 minus line 201)		85,164,889	15,660,439 202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0090 Component CCN: 15-T090	Period: From 01/01/2023 To 12/31/2023	Worksheet D-3 Date/Time Prepared: 5/30/2024 3:45 pm	
		Title XVIII	Subprovider - IRF	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	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
32.00	03200	CORONARY CARE UNIT			32.00
33.00	03300	BURN INTENSIVE CARE UNIT			33.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT			35.00
41.00	04100	SUBPROVIDER - IRF		5,121,282	41.00
42.00	04200	SUBPROVIDER			42.00
43.00	04300	NURSERY			43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	0.094675	114,296	50.00
50.01	05001	OUTPATIENT SURGERY	0.731590	9,089	50.01
51.00	05100	RECOVERY ROOM	0.085415	4,892	51.00
53.00	05300	ANESTHESIOLOGY	0.005160	9,158	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.086749	226,583	54.00
54.01	05401	RADIOLOGY-SPECIAL PROCEDURES	0.212871	51,280	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	55.00
56.00	05600	RADIOISOTOPE	0.106524	0	56.00
60.00	06000	LABORATORY	0.138608	474,416	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.465175	7,680	63.00
65.00	06500	RESPIRATORY THERAPY	0.297511	797,055	65.00
66.00	06600	PHYSICAL THERAPY	0.251568	2,051,229	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.092473	1,906,691	67.00
68.00	06800	SPEECH PATHOLOGY	0.143394	881,297	68.00
69.00	06900	ELECTROCARDIOLOGY	0.081929	30,506	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.148449	13,055	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.327634	418,268	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.255306	4,979	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.276036	734,760	73.00
76.00	03630	ULTRA SOUND	0.100251	44,507	76.00
76.01	03951	PAIN CLINIC	0.229305	61	76.01
76.02	03952	CATH LAB	0.112006	52,456	76.02
76.03	03953	ACTIVITY THERAPEUTIC	1.002728	0	76.03
76.04	03954	WOUND CARE CENTER	0.359129	6,635	76.04
76.05	03340	BARIATRIC CLINIC	1.433676	49	76.05
76.06	03030	HEALTHY LIVING CENTER	0.000000	0	76.06
76.07	03950	CV RESOURCE CENTER	0.000000	0	76.07
76.08	03955	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	76.08
76.09	03956	LACTATION CLINIC	0.000000	0	76.09
76.10	03957	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	76.10
76.11	03958	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	76.11
76.12	03959	ANTI COAGULATION CLINIC	0.698569	0	76.12
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0.000000	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000	0	78.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
91.00	09100	EMERGENCY	0.168353	8,839	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.473742	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		7,847,781	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)		7,847,781	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0090	Period: From 01/01/2023 To 12/31/2023	Worksheet D-3 Date/Time Prepared: 5/30/2024 3:45 pm	
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	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS		16,562,984	30.00
31.00	03100	INTENSIVE CARE UNIT		2,032,146	31.00
32.00	03200	CORONARY CARE UNIT		0	32.00
33.00	03300	BURN INTENSIVE CARE UNIT		0	33.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT		900,146	35.00
41.00	04100	SUBPROVIDER - I RF		0	41.00
42.00	04200	SUBPROVIDER		0	42.00
43.00	04300	NURSERY		604,234	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	0.094675	5,509,724	521,633 50.00
50.01	05001	OUTPATIENT SURGERY	0.731590	303,666	222,159 50.01
51.00	05100	RECOVERY ROOM	0.085415	607,988	51,931 51.00
53.00	05300	ANESTHESIOLOGY	0.005160	1,190,038	6,141 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.086749	4,011,694	348,010 54.00
54.01	05401	RADIOLOGY-SPECIAL PROCEDURES	0.212871	786,911	167,511 54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0 55.00
56.00	05600	RADIOISOTOPE	0.106524	157,450	16,772 56.00
60.00	06000	LABORATORY	0.138608	7,399,696	1,025,657 60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.465175	240,004	111,644 63.00
65.00	06500	RESPIRATORY THERAPY	0.297511	1,696,926	504,854 65.00
66.00	06600	PHYSICAL THERAPY	0.251568	381,550	95,986 66.00
67.00	06700	OCCUPATIONAL THERAPY	0.092473	311,910	28,843 67.00
68.00	06800	SPEECH PATHOLOGY	0.143394	311,332	44,643 68.00
69.00	06900	ELECTROCARDIOLOGY	0.081929	1,284,736	105,257 69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.148449	53,573	7,953 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.327634	3,484,779	1,141,732 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.255306	887,607	226,611 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.276036	5,310,293	1,465,832 73.00
76.00	03630	ULTRA SOUND	0.100251	664,614	66,628 76.00
76.01	03951	PAIN CLINIC	0.229305	2,526	579 76.01
76.02	03952	CATH LAB	0.112006	1,170,029	131,050 76.02
76.03	03953	ACTIVITY THERAPEUTIC	1.002728	1,459,417	1,463,398 76.03
76.04	03954	WOUND CARE CENTER	0.359129	34,751	12,480 76.04
76.05	03340	BARIATRIC CLINIC	1.433676	0	0 76.05
76.06	03030	HEALTHY LIVING CENTER	0.000000	0	0 76.06
76.07	03950	CV RESOURCE CENTER	0.000000	0	0 76.07
76.08	03955	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0 76.08
76.09	03956	LACTATION CLINIC	0.000000	0	0 76.09
76.10	03957	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0 76.10
76.11	03958	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0 76.11
76.12	03959	ANTI COAGULATION CLINIC	0.698569	6,409	4,477 76.12
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0.000000	0	0 77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000	0	0 78.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
91.00	09100	EMERGENCY	0.168353	3,353,574	564,584 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.473742	398,887	188,970 92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		41,020,084	8,525,335 200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0 201.00
202.00		Net charges (line 200 minus line 201)		41,020,084	202.00



INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0090 Component CCN: 15-T090	Period: From 01/01/2023 To 12/31/2023	Worksheet D-3 Date/Time Prepared: 5/30/2024 3:45 pm	
		Title XIX	Subprovider - IRF	TEFRA	
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	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000 ADULTS & PEDIATRICS				30.00
31.00	03100 INTENSIVE CARE UNIT				31.00
32.00	03200 CORONARY CARE UNIT				32.00
33.00	03300 BURN INTENSIVE CARE UNIT				33.00
35.00	02060 NEONATAL INTENSIVE CARE UNIT				35.00
41.00	04100 SUBPROVIDER - IRF		125,598		41.00
42.00	04200 SUBPROVIDER				42.00
43.00	04300 NURSERY				43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000 OPERATING ROOM	0.094675	0	0	50.00
50.01	05001 OUTPATIENT SURGERY	0.731590	0	0	50.01
51.00	05100 RECOVERY ROOM	0.085415	0	0	51.00
53.00	05300 ANESTHESIOLOGY	0.005160	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.086749	0	0	54.00
54.01	05401 RADIOLOGY-SPECIAL PROCEDURES	0.212871	0	0	54.01
55.00	05500 RADIOLOGY-THERAPEUTIC	0.000000	0	0	55.00
56.00	05600 RADIOISOTOPE	0.106524	0	0	56.00
60.00	06000 LABORATORY	0.138608	792	110	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.465175	0	0	63.00
65.00	06500 RESPIRATORY THERAPY	0.297511	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.251568	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.092473	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.143394	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.081929	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.148449	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.327634	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.255306	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.276036	0	0	73.00
76.00	03630 ULTRA SOUND	0.100251	0	0	76.00
76.01	03951 PAIN CLINIC	0.229305	0	0	76.01
76.02	03952 CATH LAB	0.112006	0	0	76.02
76.03	03953 ACTIVITY THERAPEUTIC	1.002728	0	0	76.03
76.04	03954 WOUND CARE CENTER	0.359129	0	0	76.04
76.05	03340 BARIATRIC CLINIC	1.433676	0	0	76.05
76.06	03030 HEALTHY LIVING CENTER	0.000000	0	0	76.06
76.07	03950 CV RESOURCE CENTER	0.000000	0	0	76.07
76.08	03955 OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	76.08
76.09	03956 LACTATION CLINIC	0.000000	0	0	76.09
76.10	03957 OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	76.10
76.11	03958 OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	76.11
76.12	03959 ANTICOAGULATION CLINIC	0.698569	0	0	76.12
77.00	07700 ALLOGENEIC STEM CELL ACQUISITION	0.000000	0	0	77.00
78.00	07800 CAR T-CELL IMMUNOTHERAPY	0.000000	0	0	78.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
91.00	09100 EMERGENCY	0.168353	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.473742	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		792	110	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net charges (line 200 minus line 201)		792	110	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0090	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part A Date/Time Prepared: 5/30/2024 3:45 pm
		Title XVIII	Hospital	PPS
		1.00		
<b>PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS</b>				
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)		14,120,607	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		4,603,695	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)		289,382	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)		194,322	2.04
3.00	Managed Care Simulated Payments		10,944,943	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		158.34	4.00
<b>Indirect Medical Education Adjustment</b>				
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)		7.80	5.00
5.01	FTE cap adjustment for qualifying hospitals under §131 of the CAA 2021 (see instructions)		0.00	5.01
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00	6.00
6.26	Rural track program FTE cap limitation adjustment after the cap-building window closed under §127 of the CAA 2021 (see instructions)		0.00	6.26
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.89	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00	7.01
7.02	Adjustment (increase or decrease) to the hospital's rural track program FTE limitation(s) for rural track programs with a rural track for Medicare GME affiliated programs in accordance with 413.75(b) and 87 FR 49075 (August 10, 2022) (see instructions)		0.00	7.02
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).		0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)		0.00	8.02
8.21	The amount of increase if the hospital was awarded FTE cap slots under §126 of the CAA 2021 (see instructions)		0.00	8.21
9.00	Sum of lines 5 and 5.01, plus line 6, plus lines 6.26 through 6.49, minus lines 7 and 7.01, plus or minus line 7.02, plus/minus line 8, plus lines 8.01 through 8.27 (see instructions)		6.91	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		2.09	10.00
11.00	FTE count for residents in dental and podiatric programs.		3.65	11.00
12.00	Current year allowable FTE (see instructions)		5.74	12.00
13.00	Total allowable FTE count for the prior year.		4.12	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.		4.56	14.00
15.00	Sum of lines 12 through 14 divided by 3.		4.81	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		4.81	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.030378	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.033048	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.030378	21.00
22.00	IME payment adjustment (see instructions)		308,239	22.00
22.01	IME payment adjustment - Managed Care (see instructions)		180,176	22.01
<b>Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA</b>				
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)		-4.82	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)		308,239	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		180,176	29.01
<b>Disproportionate Share Adjustment</b>				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		4.00	30.00
31.00	Percentage of Medicaid patient days (see instructions)		28.68	31.00
32.00	Sum of lines 30 and 31		32.68	32.00
33.00	Allowable disproportionate share percentage (see instructions)		16.17	33.00
34.00	Disproportionate share adjustment (see instructions)		756,930	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0090	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part A Date/Time Prepared: 5/30/2024 3:45 pm
		Title XVIII	Hospital	PPS
		Prior to 10/1	On/After 10/1	
		1.00	2.00	
<b>Uncompensated Care Payment Adjustment</b>				
35.00	Total uncompensated care amount (see instructions)	6,874,403,459	5,938,006,757	35.00
35.01	Factor 3 (see instructions)	0.000243131	0.000225055	35.01
35.02	Hospital UCP, including supplemental UCP (see instructions)	1,671,379	1,336,380	35.02
35.03	Pro rata share of the hospital UCP, including supplemental UCP (see instructions)	1,250,100	335,920	35.03
36.00	Total UCP adjustment (sum of columns 1 and 2 on line 35.03)	1,586,020		36.00
<b>Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)</b>				
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)	21,859,195		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)	32,763,965		48.00
				<b>Amount</b>
				1.00
49.00	Total payment for inpatient operating costs (see instructions)		30,217,949	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		1,575,083	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).		184,649	52.00
53.00	Nursing and Allied Health Managed Care payment		0	53.00
54.00	Special add-on payments for new technologies		80,501	54.00
54.01	Islet isolation add-on payment		0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)		0	55.00
55.01	Cellular therapy acquisition cost (see instructions)		0	55.01
56.00	Cost of physicians' services in a teaching hospital (see instructions)		0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).		0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		175,508	58.00
59.00	Total (sum of amounts on lines 49 through 58)		32,233,690	59.00
60.00	Primary payer payments		0	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		32,233,690	61.00
62.00	Deductibles billed to program beneficiaries		1,849,204	62.00
63.00	Coinurance billed to program beneficiaries		54,378	63.00
64.00	Allowable bad debts (see instructions)		297,946	64.00
65.00	Adjusted reimbursable bad debts (see instructions)		193,665	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		282,051	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		30,523,773	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)		0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)		0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	70.00
70.50	Rural Community Hospital Demonstration Project (\$410A Demonstration) adjustment (see instructions)		0	70.50
70.75	N95 respirator payment adjustment amount (see instructions)		0	70.75
70.87	Demonstration payment adjustment amount before sequestration		0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)		0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		0	70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)		-13,513	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)		-26,013	70.91
70.92	Bundled Model 1 discount amount (see instructions)		0	70.92
70.93	HVBP payment adjustment amount (see instructions)		-30,177	70.93
70.94	HRR adjustment amount (see instructions)		-59,442	70.94
70.95	Recovery of accelerated depreciation		0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0090	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part A Date/Time Prepared: 5/30/2024 3:45 pm
		Title XVIII	Hospital	PPS
		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0	70.97
70.98	Low Volume Payment-3	0	0	70.98
70.99	HAC adjustment amount (see instructions)		239,808	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		30,154,820	71.00
71.01	Sequestration adjustment (see instructions)		603,096	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
71.03	Sequestration adjustment-PARHM pass-throughs		0	71.03
72.00	Interim payments		28,964,687	72.00
72.01	Interim payments-PARHM		0	72.01
73.00	Tentative settlement (for contractor use only)		0	73.00
73.01	Tentative settlement-PARHM (for contractor use only)		0	73.01
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)		587,037	74.00
74.01	Balance due provider/program-PARHM (see instructions)		0	74.01
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		7,905,933	75.00
<b>TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)</b>				
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. 1, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00
		Prior to 10/1	On/After 10/1	
		1.00	2.00	
<b>HSP Bonus Payment Amount</b>				
100.00	HSP bonus amount (see instructions)		6,117,128	2,061,450
<b>HVBP Adjustment for HSP Bonus Payment</b>				
101.00	HVBP adjustment factor (see instructions)		1.0000000000	0.9934449361
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)		0	-13,513
<b>HRR Adjustment for HSP Bonus Payment</b>				
103.00	HRR adjustment factor (see instructions)		0.9975	0.9948
104.00	HRR adjustment amount for HSP bonus payment (see instructions)		-15,293	-10,720
<b>Rural Community Hospital Demonstration Project (\$410A Demonstration) Adjustment</b>				
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.			
<b>Cost Reimbursement</b>				
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. 11, line 49)			
202.00	Medicare discharges (see instructions)			
203.00	Case-mix adjustment factor (see instructions)			
<b>Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)</b>				
204.00	Medicare target amount			
205.00	Case-mix adjusted target amount (line 203 times line 204)			
206.00	Medicare inpatient routine cost cap (line 202 times line 205)			
<b>Adjustment to Medicare Part A Inpatient Reimbursement</b>				
207.00	Program reimbursement under the \$410A Demonstration (see instructions)			
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)			
209.00	Adjustment to Medicare IPPS payments (see instructions)			
210.00	Reserved for future use			
211.00	Total adjustment to Medicare IPPS payments (see instructions)			
<b>Comparison of PPS versus Cost Reimbursement</b>				
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)			
213.00	Low-volume adjustment (see instructions)			
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)			

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 15-0090

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

Worksheet E  
Part A Exhibit 4  
Date/Time Prepared:  
5/30/2024 3:45 pm

		Title XVIII			Hospital		PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	14,120,607	0	14,120,607		14,120,607	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	4,603,695	0		4,603,695	4,603,695	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00						2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0	2.01
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	289,382	0	289,382		289,382	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	194,322	0		194,322	194,322	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	10,944,943	0	8,203,456	2,741,487	10,944,943	4.00
<b>Indirect Medical Education Adjustment</b>								
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.030378	0.030378	0.030378	0.030378		5.00
6.00	IME payment adjustment (see instructions)	22.00	308,239	0	232,453	75,786	308,239	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	180,176	0	135,046	45,130	180,176	6.01
<b>Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA</b>								
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	308,239	0	232,453	75,786	308,239	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	180,176	0	135,046	45,130	180,176	9.01
<b>Disproportionate Share Adjustment</b>								
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1617	0.1617	0.1617	0.1617		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	756,930	0	570,826	186,104	756,930	11.00
11.01	Uncompensated care payments	36.00	1,586,020	0	1,250,100	335,920	1,586,020	11.01
<b>Additional payment for high percentage of ESRD beneficiary discharges</b>								
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	21,859,195	0	16,463,368	5,395,827	21,859,195	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	32,763,965	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	30,217,949	0	24,776,992	5,440,957	30,217,949	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	1,575,083	0	1,178,890	396,193	1,575,083	16.00
17.00	Special add-on payments for new technologies	54.00	80,501	0	80,501	0	80,501	17.00
17.01	Net organ acquisition cost							17.01

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 15-0090

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

Worksheet E  
Part A Exhibit 4  
Date/Time Prepared:  
5/30/2024 3:45 pm

		Title XVIII			Hospital		PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00
19.00	SUBTOTAL			0	26,036,383	5,837,150	31,873,533	19.00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	1,422,103	0	1,065,110	356,993	1,422,103	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	29,968	0	21,648	8,320	29,968	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0181	0.0181	0.0181	0.0181		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	25,740	0	19,278	6,462	25,740	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0684	0.0684	0.0684	0.0684		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	97,272	0	72,854	24,418	97,272	25.00
26.00	Total prospective capital payments (see instructions)	12.00	1,575,083	0	1,178,890	396,193	1,575,083	26.00
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.000000	0.000000		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			0		0	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				0	0	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5		Provider CCN: 15-0090		Period: From 01/01/2023 To 12/31/2023		Worksheet E Part A Exhibit 5 Date/Time Prepared: 5/30/2024 3:45 pm	
		Title XVIII		Hospital		PPS	
	Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A	Period to 10/01	Period on after 10/01	Total (col s. 2 and 3)		
	0	1.00	2.00	3.00	4.00		
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	14,120,607	14,120,607		14,120,607	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	4,603,695		4,603,695	4,603,695	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00					2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	289,382	289,382		289,382	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	194,322		194,322	194,322	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	10,944,943	8,203,456	2,741,487	10,944,943	4.00
<b>Indirect Medical Education Adjustment</b>							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.030378	0.030378	0.030378		5.00
6.00	IME payment adjustment (see instructions)	22.00	308,239	232,453	75,786	308,239	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	180,176	135,046	45,130	180,176	6.01
<b>Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA</b>							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	308,239	232,453	75,786	308,239	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	180,176	135,046	45,130	180,176	9.01
<b>Disproportionate Share Adjustment</b>							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1617	0.1617	0.1617		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	756,930	570,826	186,104	756,930	11.00
11.01	Uncompensated care payments	36.00	1,586,020	1,250,100	335,920	1,586,020	11.01
<b>Additional payment for high percentage of ESRD beneficiary discharges</b>							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	21,859,195	16,463,368	5,395,827	21,859,195	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	32,763,965	24,695,088	8,068,877	32,763,965	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	30,217,949	22,772,204	7,445,745	30,217,949	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	1,575,083	1,178,890	396,193	1,575,083	16.00
17.00	Special add-on payments for new technologies	54.00	80,501	80,501	0	80,501	17.00
17.01	Net organ acquisition cost						17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	<b>SUBTOTAL</b>			24,031,595	7,841,938	31,873,533	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 15-0090

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

Worksheet E  
Part A Exhibit 5  
Date/Time Prepared:  
5/30/2024 3:45 pm

		Title XVIII		Hospital		PPS	
		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	1,422,103	1,065,110	356,993	1,422,103	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	29,968	21,648	8,320	29,968	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0181	0.0181	0.0181		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	25,740	19,278	6,462	25,740	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0684	0.0684	0.0684		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	97,272	72,854	24,418	97,272	25.00
26.00	Total prospective capital payments (see instructions)	12.00	1,575,083	1,178,890	396,193	1,575,083	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
27.00							27.00
28.00	Low volume adjustment prior to October 1	70.96	0	0		0	28.00
29.00	Low volume adjustment on or after October 1	70.97	0		0	0	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	-30,177	0	-30,177	-30,177	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	-13,513	0	-13,513	-13,513	30.01
31.00	HRR adjustment (see instructions)	70.94	-59,442	-35,504	-23,938	-59,442	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	-26,013	-15,293	-10,720	-26,013	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		239,808	0	239,808	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		Y				100.00



CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0090	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part B Date/Time Prepared: 5/30/2024 3:45 pm
		Title XVIII	Hospital	PPS
		1.00		
<b>PART B - MEDICAL AND OTHER HEALTH SERVICES</b>				
1.00	Medical and other services (see instructions)		1,837	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		13,246,113	2.00
3.00	OPPS or REH payments		11,200,319	3.00
4.00	Outlier payment (see instructions)		51,282	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		55,134	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		1,837	11.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
<b>Reasonable charges</b>				
12.00	Ancillary service charges		6,656	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)		6,656	14.00
<b>Customary charges</b>				
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)		6,656	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		4,819	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (see instructions)		1,837	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)		11,306,735	24.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
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)		1,873,118	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)		9,435,454	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		73,183	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)		9,508,637	30.00
31.00	Primary payer payments		1,087	31.00
32.00	Subtotal (line 30 minus line 31)		9,507,550	32.00
<b>ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)</b>				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		148,252	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		96,364	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		111,199	36.00
37.00	Subtotal (see instructions)		9,603,914	37.00
38.00	MSP-LCC reconciliation amount from PS&R		-2	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	39.50
39.75	N95 respirator payment adjustment amount (see instructions)		0	39.75
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		19,000	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		9,603,916	40.00
40.01	Sequestration adjustment (see instructions)		192,078	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		9,360,170	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)		51,668	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
<b>TO BE COMPLETED BY CONTRACTOR</b>				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0090	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part B Date/Time Prepared: 5/30/2024 3:45 pm
		Title XVIII	Hospital PPS
			1.00
200.00	MEDI CARE PART B ANCI LLARY COSTS Part B Combined Billed Days		0 200.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0090 Component CCN: 15-T090	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part B Date/Time Prepared: 5/30/2024 3:45 pm
		Title XVIII	Subprovider - IRF	PPS
		1.00		
<b>PART B - MEDICAL AND OTHER HEALTH SERVICES</b>				
1.00	Medical and other services (see instructions)		62	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		23	2.00
3.00	OPPS or REH payments		122	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		1	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		62	11.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
<b>Reasonable charges</b>				
12.00	Ancillary service charges		225	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)		225	14.00
<b>Customary charges</b>				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		225	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		163	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)		62	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)		123	24.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
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)		0	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)		185	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)		185	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		185	32.00
<b>ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)</b>				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	36.00
37.00	Subtotal (see instructions)		185	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)		185	40.00
40.01	Sequestration adjustment (see instructions)		4	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		176	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)		5	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
<b>TO BE COMPLETED BY CONTRACTOR</b>				
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: 15-0090 Component CCN: 15-T090	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part B Date/Time Prepared: 5/30/2024 3:45 pm
		Title XVIII	Subprovider - IRF	PPS
				1.00
94.00	Total (sum of lines 91 and 93)			0 94.00
				1.00
200.00	MEDI CARE PART B ANCILLARY COSTS Part B Combined Billed Days			200.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-0090

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

Worksheet E-1  
Part I  
Date/Time Prepared:  
5/30/2024 3:45 pm

		Title XVIII		Hospital		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		28,964,687		9,360,170	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)		28,964,687		9,360,170	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		587,037		51,668	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		29,551,724		9,411,838	7.00	
				Contractor Number	NPR Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor					8.00	

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED		Provider CCN: 15-0090 Component CCN: 15-T090	Period: From 01/01/2023 To 12/31/2023	Worksheet E-1 Part I Date/Time Prepared: 5/30/2024 3:45 pm	
		Title XVIII	Subprovider - IRF	PPS	
		Inpatient Part A		Part B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount
		1.00	2.00	3.00	4.00
1.00	Total interim payments paid to provider				176 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		5,474,856		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)				0 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)		5,474,856		176 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)				0 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)				0 6.00
6.01	SETTLEMENT TO PROVIDER		0		5 6.01
6.02	SETTLEMENT TO PROGRAM		96,351		0 6.02
7.00	Total Medicare program liability (see instructions)		5,378,505		181 7.00
				Contractor Number	NPR Date (Mo/Day/Yr)
			0	1.00	2.00
8.00	Name of Contractor				0 8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT		Provider CCN: 15-0090	Period: From 01/01/2023 To 12/31/2023	Worksheet E-1 Part II Date/Time Prepared: 5/30/2024 3:45 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: 15-0090 Component CCN: 15-T090	Period: From 01/01/2023 To 12/31/2023	Worksheet E-3 Part III Date/Time Prepared: 5/30/2024 3:45 pm
		Title XVIII	Subprovider - IRF	PPS
				1.00
<b>PART III - MEDICARE PART A SERVICES - IRF PPS</b>				
1.00	Net Federal PPS Payment (see instructions)			5,100,450 1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)			0.0238 2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)			87,728 3.00
4.00	Outlier Payments			341,688 4.00
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)			0.00 5.00
5.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)			0.00 5.01
6.00	New Teaching program adjustment. (see instructions)			0.00 6.00
7.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)			0.00 7.00
8.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)			0.00 8.00
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)			0.00 9.00
10.00	Average Daily Census (see instructions)			10.860274 10.00
11.00	Teaching Adjustment Factor (see instructions)			0.000000 11.00
12.00	Teaching Adjustment (see instructions)			0 12.00
13.00	Total PPS Payment (see instructions)			5,529,866 13.00
14.00	Nursing and Allied Health Managed Care payments (see instruction)			0 14.00
15.00	Organ acquisition (DO NOT USE THIS LINE)			0 15.00
16.00	Cost of physicians' services in a teaching hospital (see instructions)			0 16.00
17.00	Subtotal (see instructions)			5,529,866 17.00
18.00	Primary payer payments			0 18.00
19.00	Subtotal (line 17 less line 18).			5,529,866 19.00
20.00	Deductibles			43,200 20.00
21.00	Subtotal (line 19 minus line 20)			5,486,666 21.00
22.00	Coinsurance			8,800 22.00
23.00	Subtotal (line 21 minus line 22)			5,477,866 23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			0 24.00
25.00	Adjusted reimbursable bad debts (see instructions)			0 25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0 26.00
27.00	Subtotal (sum of lines 23 and 25)			5,477,866 27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 49)			0 28.00
29.00	Other pass through costs (see instructions)			10,404 29.00
30.00	Outlier payments reconciliation			0 30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 31.00
31.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 31.50
31.98	Recovery of accelerated depreciation.			0 31.98
31.99	Demonstration payment adjustment amount before sequestration			0 31.99
32.00	Total amount payable to the provider (see instructions)			5,488,270 32.00
32.01	Sequestration adjustment (see instructions)			109,765 32.01
32.02	Demonstration payment adjustment amount after sequestration			0 32.02
33.00	Interim payments			5,474,856 33.00
34.00	Tentative settlement (for contractor use only)			0 34.00
35.00	Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34)			-96,351 35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0 36.00
<b>TO BE COMPLETED BY CONTRACTOR</b>				
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4			341,688 50.00
51.00	Outlier reconciliation adjustment amount (see instructions)			0 51.00
52.00	The rate used to calculate the Time Value of Money			0.00 52.00
53.00	Time Value of Money (see instructions)			0 53.00
<b>FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AND BEGINNING ON OR BEFORE MAY 11, 2023 (THE END OF THE COVID-19 PHE)</b>				
99.00	Teaching Adjustment Factor for the cost reporting period immediately preceding February 29, 2020.			0.000000 99.00
99.01	Calculated Teaching Adjustment Factor for the current year. (see instructions)			0.000000 99.01



CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0090	Period: From 01/01/2023 To 12/31/2023	Worksheet E-3 Part VII Date/Time Prepared: 5/30/2024 3:45 pm
		Title XIX	Hospital	Cost
			Inpatient	Outpatient
			1.00	2.00
<b>PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES</b>				
<b>COMPUTATION OF NET COST OF COVERED SERVICES</b>				
1.00	Inpatient hospital/SNF/NF services		14,100,886	1.00
2.00	Medical and other services			2.00
3.00	Organ acquisition (certified transplant programs only)		0	3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		14,100,886	4.00
5.00	Inpatient primary payer payments		0	5.00
6.00	Outpatient primary payer payments			6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		14,100,886	7.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
<b>Reasonable Charges</b>				
8.00	Routine service charges		0	8.00
9.00	Ancillary service charges		41,020,084	9.00
10.00	Organ acquisition charges, net of revenue		0	10.00
11.00	Incentive from target amount computation		0	11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		41,020,084	12.00
<b>CUSTOMARY CHARGES</b>				
13.00	Amount actually collected from patients liable for payment for services on a charge basis		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	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	15.00
16.00	Total customary charges (see instructions)		41,020,084	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		26,919,198	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		0	18.00
19.00	Interns and Residents (see instructions)		0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)		0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		14,100,886	21.00
<b>PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.</b>				
22.00	Other than outlier payments		0	22.00
23.00	Outlier payments		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	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)		14,100,886	29.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
30.00	Excess of reasonable cost (from line 18)		0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		14,100,886	31.00
32.00	Deductibles		0	32.00
33.00	Coinsurance		0	33.00
34.00	Allowable bad debts (see instructions)		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)		14,100,886	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	37.00
38.00	Subtotal (line 36 ± line 37)		14,100,886	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)		14,100,886	40.00
41.00	Interim payments		14,100,886	41.00
42.00	Balance due provider/program (line 40 minus line 41)		0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2		0	43.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0090 Component CCN: 15-T090	Period: From 01/01/2023 To 12/31/2023	Worksheet E-3 Part VII Date/Time Prepared: 5/30/2024 3:45 pm	
		Title XIX	Subprovider - IRF	TEFRA	
				Inpatient 1.00	Outpatient 2.00
<b>PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES</b>					
<b>COMPUTATION OF NET COST OF COVERED SERVICES</b>					
1.00	Inpatient hospital/SNF/NF services		7		1.00
2.00	Medical and other services			0	2.00
3.00	Organ acquisition (certified transplant programs only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		7	0	4.00
5.00	Inpatient primary payer payments		0		5.00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		7	0	7.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>					
<b>Reasonable Charges</b>					
8.00	Routine service charges		0		8.00
9.00	Ancillary service charges		792	0	9.00
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		792	0	12.00
<b>CUSTOMARY CHARGES</b>					
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)		792	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		785	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		0	0	18.00
19.00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)		0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		7	0	21.00
<b>PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.</b>					
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	0	29.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>					
30.00	Excess of reasonable cost (from line 18)		0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		7	0	31.00
32.00	Deductibles		0		32.00
33.00	Coinsurance		0		33.00
34.00	Allowable bad debts (see instructions)		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	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		37.00
38.00	Subtotal (line 36 ± line 37)		7	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)		0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		7	0	40.00
41.00	Interim payments		7	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)		0		42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2		0		43.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 15-0090	Period: From 01/01/2023 To 12/31/2023	Worksheet E-4 Date/Time Prepared: 5/30/2024 3:45 pm	
		Title XVIII	Hospital	PPS	
				1.00	
<b>COMPUTATION OF TOTAL DIRECT GME AMOUNT</b>					
1.00	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996.			7.76	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			0.86	3.00
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79 (m). (see instructions for cost reporting periods straddling 7/1/2011)			0.00	3.01
3.02	Adjustment (increase or decrease) to the hospital's rural track FTE limitation(s) for rural track programs with a rural track Medicare GME affiliation agreement in accordance with 413.75(b) and 87 FR 49075 (August 10, 2022) (see instructions)			0.00	3.02
4.00	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f))			0.00	4.00
4.01	ACA Section 5503 increase to the Direct GME FTE Cap (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.01
4.02	ACA Section 5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.02
4.21	The amount of increase if the hospital was awarded FTE cap slots under §126 of the CAA 2021 (see instructions)			0.00	4.21
5.00	FTE adjusted cap (line 1 plus and 1.01, plus line 2, plus lines 2.26 through 2.49, minus lines 3 and 3.01, plus or minus line 3.02, plus or minus line 4, plus lines 4.01 through 4.27)			6.90	5.00
6.00	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)			2.09	6.00
7.00	Enter the lesser of line 5 or line 6			2.09	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	2.09	2.09	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	2.09	2.09	9.00
10.00	Weighted dental and podiatric resident FTE count for the current year		3.65		10.00
10.01	Unweighted dental and podiatric resident FTE count for the current year		3.65		10.01
11.00	Total weighted FTE count		5.74		11.00
12.00	Total weighted resident FTE count for the prior cost reporting year (see instructions)	0.00	3.79		12.00
13.00	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	0.21	4.76		13.00
14.00	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	0.07	4.76		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	0.07	4.76		17.00
18.00	Per resident amount	106,358.68	102,792.11		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	7,445	489,290	496,735	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)			496,735	25.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 15-0090	Period: From 01/01/2023 To 12/31/2023	Worksheet E-4 Date/Time Prepared: 5/30/2024 3:45 pm
		Title XVIII	Hospital	PPS
		Inpatient Part A 1.00	Managed Care 2.00	Total 3.00
<b>COMPUTATION OF PROGRAM PATIENT LOAD</b>				
26.00	Inpatient Days (see instructions) (Title XIX - see S-2 Part IX, line 3.02, column 2)	10,621	5,998	26.00
27.00	Total Inpatient Days (see instructions)	31,640	31,640	27.00
28.00	Ratio of inpatient days to total inpatient days	0.335683	0.189570	28.00
29.00	Program direct GME amount	166,745	94,166	29.00
29.01	Percent reduction for MA DGME		3.27	29.01
30.00	Reduction for direct GME payments for Medicare Advantage		3,079	30.00
31.00	Net Program direct GME amount		257,832	31.00
				1.00
<b>DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING PROGRAM AND PARAMEDICAL EDUCATION COSTS)</b>				
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
<b>APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII ONLY</b>				
<b>Part A Reasonable Cost</b>				
37.00	Reasonable cost (see instructions)			33,562,834 37.00
38.00	Organ acquisition and HSCT acquisition costs (see instructions)			0 38.00
39.00	Cost of physicians' services in a teaching hospital (see instructions)			0 39.00
40.00	Primary payer payments (see instructions)			0 40.00
41.00	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)			33,562,834 41.00
<b>Part B Reasonable Cost</b>				
42.00	Reasonable cost (see instructions)			13,303,170 42.00
43.00	Primary payer payments (see instructions)			1,087 43.00
44.00	Total Part B reasonable cost (line 42 minus line 43)			13,302,083 44.00
45.00	Total reasonable cost (sum of lines 41 and 44)			46,864,917 45.00
46.00	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)			0.716161 46.00
47.00	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)			0.283839 47.00
<b>ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B</b>				
48.00	Total program GME payment (line 31)			257,832 48.00
49.00	Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions)			184,649 49.00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)			73,183 50.00

OUTLIER RECONCILIATION AT TENTATIVE SETTLEMENT		Provider CCN: 15-0090	Period: From 01/01/2023 To 12/31/2023	Worksheet E-5 Date/Time Prepared: 5/30/2024 3:45 pm
Title XVIII			PPS	
			1.00	
<b>TO BE COMPLETED BY CONTRACTOR</b>				
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: 15-0090

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

Worksheet G

Date/Time Prepared:  
5/30/2024 3:45 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
<b>CURRENT ASSETS</b>						
1.00	Cash on hand in banks	-97,069,518	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	113,493,435	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-84,584,998	0	0	0	6.00
7.00	Inventory	3,301,871	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	3,530,934	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)	-61,328,276	0	0	0	11.00
<b>FIXED ASSETS</b>						
12.00	Land	694,364	0	0	0	12.00
13.00	Land improvements	10,382,022	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	74,382,828	0	0	0	15.00
16.00	Accumulated depreciation	0	0	0	0	16.00
17.00	Leasehold improvements	178,989	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	0	0	0	0	23.00
24.00	Accumulated depreciation	0	0	0	0	24.00
25.00	Minor equipment depreciable	179,926,808	0	0	0	25.00
26.00	Accumulated depreciation	-177,693,107	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	87,871,904	0	0	0	30.00
<b>OTHER ASSETS</b>						
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	45,303,830	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	45,303,830	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	71,847,458	0	0	0	36.00
<b>CURRENT LIABILITIES</b>						
37.00	Accounts payable	8,931,205	0	0	0	37.00
38.00	Salaries, wages, and fees payable	0	0	0	0	38.00
39.00	Payroll taxes payable	7,848,556	0	0	0	39.00
40.00	Notes and loans payable (short term)	508,866	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	819,799	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	18,108,426	0	0	0	45.00
<b>LONG TERM LIABILITIES</b>						
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	3,425,333	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	3,425,333	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	21,533,759	0	0	0	51.00
<b>CAPITAL ACCOUNTS</b>						
52.00	General fund balance	50,313,699				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)	50,313,699	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	71,847,458	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 15-0090

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

Worksheet G-1

Date/Time Prepared:  
5/30/2024 3:45 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		23,489,410		0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		26,327,912			2.00
3.00	Total (sum of line 1 and line 2)		49,817,322		0	3.00
4.00	ADJSUTMENT TO BALANCE	496,376		0		4.00
5.00	ADJUMENT TO BALANCE	1		0		5.00
6.00		0		0		6.00
7.00		0		0		7.00
8.00		0		0		8.00
9.00		0		0		9.00
10.00	Total additions (sum of line 4-9)		496,377		0	10.00
11.00	Subtotal (line 3 plus line 10)		50,313,699		0	11.00
12.00	Deductions (debit adjustments) (speci fy)	0		0		12.00
13.00		0		0		13.00
14.00		0		0		14.00
15.00		0		0		15.00
16.00		0		0		16.00
17.00		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)		50,313,699		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	ADJSUTMENT TO BALANCE		0			4.00
5.00	ADJUMENT TO BALANCE		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) (speci fy)		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: 15-0090

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

Worksheet G-2  
Parts I & II  
Date/Time Prepared:  
5/30/2024 3:45 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
<b>PART I - PATIENT REVENUES</b>					
General Inpatient Routine Services					
1.00	Hospital	70,066,155		70,066,155	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF	7,542,016		7,542,016	3.00
4.00	SUBPROVIDER	0		0	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)	77,608,171		77,608,171	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	10,388,787		10,388,787	11.00
12.00	CORONARY CARE UNIT	0		0	12.00
13.00	BURN INTENSIVE CARE UNIT	0		0	13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	NEONATAL INTENSIVE CARE UNIT	1,241,031		1,241,031	15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	11,629,818		11,629,818	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	89,237,989		89,237,989	17.00
18.00	Ancillary services	239,052,630	384,118,486	623,171,116	18.00
19.00	Outpatient services	19,998,996	52,029,708	72,028,704	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		0	0	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)	348,289,615	436,148,194	784,437,809	28.00
<b>PART II - OPERATING EXPENSES</b>					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		212,045,213		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)		212,045,213		43.00



STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 15-0090

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

Worksheet G-3

Date/Time Prepared:  
5/30/2024 3:45 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	784,437,809	1.00
2.00	Less contractual allowances and discounts on patients' accounts	552,077,364	2.00
3.00	Net patient revenues (line 1 minus line 2)	232,360,445	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	212,045,213	4.00
5.00	Net income from service to patients (line 3 minus line 4)	20,315,232	5.00
<b>OTHER INCOME</b>			
6.00	Contributions, donations, bequests, etc	0	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	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER OPERATING REVENUE	5,095,422	24.00
24.01	OTHER NON OPERATING REVENUE	917,258	24.01
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (sum of lines 6-24)	6,012,680	25.00
26.00	Total (line 5 plus line 25)	26,327,912	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	26,327,912	29.00

ANALYSIS OF HOSPITAL-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 15-0090

Period: From 01/01/2023

Worksheet H

HHA CCN: 15-7145

To 12/31/2023

Date/Time Prepared: 5/30/2024 3:45 pm

Home Health Agency I

PPS

	Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of col.s. 1 thru 5)		
	1.00	2.00	3.00	4.00	5.00	6.00		
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	Capital Related - Bldg. & Fixtures		0		120,279	120,279	1.00	
2.00	Capital Related - Movable Equipment		0		831	831	2.00	
3.00	Plant Operation & Maintenance	0	0	0	51,825	51,825	3.00	
4.00	Transportation	0	43,285	0	0	43,285	4.00	
5.00	Administrative and General	1,645,810	3	85,699	142,772	1,874,284	5.00	
<b>HHA REIMBURSABLE SERVICES</b>								
6.00	Skilled Nursing Care	2,786,981	4	145,121	0	2,932,106	6.00	
7.00	Physical Therapy	2,209,587	3	325,384	0	2,534,974	7.00	
8.00	Occupational Therapy	231,943	1	97,973	0	329,917	8.00	
9.00	Speech Pathology	12,082	0	25,547	0	37,629	9.00	
10.00	Medical Social Services	162,536	0	8,463	0	170,999	10.00	
11.00	Home Health Aide	21,273	0	87,227	0	108,500	11.00	
12.00	Supplies (see instructions)	0	0	0	285,094	285,094	12.00	
13.00	Drugs	0	0	0	5,851	5,851	13.00	
14.00	DME	0	0	0	0	0	14.00	
<b>HHA NONREIMBURSABLE SERVICES</b>								
15.00	Home Dialysis Aide Services	0	0	0	0	0	15.00	
16.00	Respiratory Therapy	0	0	0	0	0	16.00	
17.00	Private Duty Nursing	0	0	0	0	0	17.00	
18.00	Clinic	0	0	0	0	0	18.00	
19.00	Health Promotion Activities	0	0	0	0	0	19.00	
20.00	Day Care Program	0	0	0	0	0	20.00	
21.00	Home Delivered Meals Program	0	0	0	0	0	21.00	
22.00	Homemaker Service	0	0	0	0	0	22.00	
23.00	All Others (specify)	0	0	0	0	0	23.00	
23.50	Tel emedicine	0	0	0	0	0	23.50	
24.00	Total (sum of lines 1-23)	7,070,212	11	43,285	775,414	606,652	8,495,574	24.00
	Reclassifi cation	Reclassifi ed Trial Balance (col. 6 + col.7)	Adjustments	Net Expenses for Allocation (col. 8 + col. 9)				
	7.00	8.00	9.00	10.00				
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	Capital Related - Bldg. & Fixtures	-120,279	0	0	0		1.00	
2.00	Capital Related - Movable Equipment	-831	0	0	0		2.00	
3.00	Plant Operation & Maintenance	0	51,825	0	51,825		3.00	
4.00	Transportation	0	43,285	0	43,285		4.00	
5.00	Administrative and General	0	1,874,284	0	1,874,284		5.00	
<b>HHA REIMBURSABLE SERVICES</b>								
6.00	Skilled Nursing Care	0	2,932,106	0	2,932,106		6.00	
7.00	Physical Therapy	0	2,534,974	0	2,534,974		7.00	
8.00	Occupational Therapy	0	329,917	0	329,917		8.00	
9.00	Speech Pathology	0	37,629	0	37,629		9.00	
10.00	Medical Social Services	0	170,999	0	170,999		10.00	
11.00	Home Health Aide	-3	108,497	0	108,497		11.00	
12.00	Supplies (see instructions)	-285,094	0	0	0		12.00	
13.00	Drugs	-5,851	0	0	0		13.00	
14.00	DME	0	0	0	0		14.00	
<b>HHA NONREIMBURSABLE SERVICES</b>								
15.00	Home Dialysis Aide Services	0	0	0	0		15.00	
16.00	Respiratory Therapy	0	0	0	0		16.00	
17.00	Private Duty Nursing	0	0	0	0		17.00	
18.00	Clinic	0	0	0	0		18.00	
19.00	Health Promotion Activities	0	0	0	0		19.00	
20.00	Day Care Program	0	0	0	0		20.00	
21.00	Home Delivered Meals Program	0	0	0	0		21.00	
22.00	Homemaker Service	0	0	0	0		22.00	
23.00	All Others (specify)	0	0	0	0		23.00	
23.50	Tel emedicine	0	0	0	0		23.50	
24.00	Total (sum of lines 1-23)	-412,058	8,083,516	0	8,083,516		24.00	

Column, 6 line 24 should agree with the Worksheet A, column 3, line 101, or subscript as applicable.

COST ALLOCATION - HHA GENERAL SERVICE COST		Provider CCN: 15-0090	Period: From 01/01/2023 To 12/31/2023	Worksheet H-1 Part I Date/Time Prepared: 5/30/2024 3:45 pm
		HHA CCN: 15-7145	Home Health Agency I	PPS

	Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Capital Related Costs		Plant Operation & Maintenance	Transportation	Subtotal (cols. 0-4)	
		Bldgs & Fixtures	Movable Equipment				
		1.00	2.00				
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	Capital Related - Bldg. & Fixtures	0	0			0	1.00
2.00	Capital Related - Movable Equipment	0	0			0	2.00
3.00	Plant Operation & Maintenance	51,825	0	51,825		0	3.00
4.00	Transportation	43,285	0	0	43,285	0	4.00
5.00	Administrative and General	1,874,284	0	51,825	43,285	1,969,394	5.00
<b>HHA REIMBURSABLE SERVICES</b>							
6.00	Skilled Nursing Care	2,932,106	0	0	0	2,932,106	6.00
7.00	Physical Therapy	2,534,974	0	0	0	2,534,974	7.00
8.00	Occupational Therapy	329,917	0	0	0	329,917	8.00
9.00	Speech Pathology	37,629	0	0	0	37,629	9.00
10.00	Medical Social Services	170,999	0	0	0	170,999	10.00
11.00	Home Health Aide	108,497	0	0	0	108,497	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	14.00
<b>HHA NONREIMBURSABLE SERVICES</b>							
15.00	Home Dialysis Aide Services	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	8,083,516	0	51,825	43,285	8,083,516	24.00
		Administrative & General	Total (cols. 4A + 5)				
		5.00	6.00				
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	Capital Related - Bldg. & Fixtures						1.00
2.00	Capital Related - Movable Equipment						2.00
3.00	Plant Operation & Maintenance						3.00
4.00	Transportation						4.00
5.00	Administrative and General	1,969,394					5.00
<b>HHA REIMBURSABLE SERVICES</b>							
6.00	Skilled Nursing Care	944,447	3,876,553				6.00
7.00	Physical Therapy	816,530	3,351,504				7.00
8.00	Occupational Therapy	106,268	436,185				8.00
9.00	Speech Pathology	12,121	49,750				9.00
10.00	Medical Social Services	55,080	226,079				10.00
11.00	Home Health Aide	34,948	143,445				11.00
12.00	Supplies (see instructions)	0	0				12.00
13.00	Drugs	0	0				13.00
14.00	DME	0	0				14.00
<b>HHA NONREIMBURSABLE SERVICES</b>							
15.00	Home Dialysis Aide Services	0	0				15.00
16.00	Respiratory Therapy	0	0				16.00
17.00	Private Duty Nursing	0	0				17.00
18.00	Clinic	0	0				18.00
19.00	Health Promotion Activities	0	0				19.00
20.00	Day Care Program	0	0				20.00
21.00	Home Delivered Meals Program	0	0				21.00
22.00	Homemaker Service	0	0				22.00
23.00	All Others (specify)	0	0				23.00
23.50	Telemedicine	0	0				23.50
24.00	Total (sum of lines 1-23)		8,083,516				24.00

COST ALLOCATION - HHA STATISTICAL BASIS

Provider CCN: 15-0090

Period: From 01/01/2023

Worksheet H-1

HHA CCN: 15-7145

To 12/31/2023

Part II  
Date/Time Prepared:  
5/30/2024 3:45 pm

Home Health Agency I

PPS

	Capital Related Costs		Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	Administrative & General (ACCUM. COST)		
	Bl dgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)						
	1.00	2.00						3.00
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	Capital Related - Bldg. & Fixtures	0			0		1.00	
2.00	Capital Related - Movable Equipment		0		0		2.00	
3.00	Plant Operation & Maintenance	0	0	100	0		3.00	
4.00	Transportation (see instructions)	0	0	0	100		4.00	
5.00	Administrative and General	0	0	100	100	-1,969,394	6,114,122	5.00
<b>HHA REIMBURSABLE SERVICES</b>								
6.00	Skilled Nursing Care	0	0	0	0	0	2,932,106	6.00
7.00	Physical Therapy	0	0	0	0	0	2,534,974	7.00
8.00	Occupational Therapy	0	0	0	0	0	329,917	8.00
9.00	Speech Pathology	0	0	0	0	0	37,629	9.00
10.00	Medical Social Services	0	0	0	0	0	170,999	10.00
11.00	Home Health Aide	0	0	0	0	0	108,497	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
<b>HHA NONREIMBURSABLE SERVICES</b>								
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	0	0	100	100	-1,969,394	6,114,122	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	51,825	43,285		1,969,394	25.00
26.00	Unit Cost Multiplier	0.000000	0.000000	518.250000	432.850000		0.322106	26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS		Provider CCN: 15-0090	Period: From 01/01/2023	Worksheet H-2 Part I Date/Time Prepared: 5/30/2024 3:45 pm
		HHA CCN: 15-7145	To 12/31/2023	
			Home Health Agency I	PPS

Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	OTHER ADMINISTRATIVE AND GENERAL		
		BLDG & FIXT	MVBLE EQUIP					
		0	1.00					2.00
1.00	Administrative and General	0	5,761	237	460,835	466,833	133,126	1.00
2.00	Skilled Nursing Care	3,876,553	9,723	404	780,369	4,667,049	1,330,893	2.00
3.00	Physical Therapy	3,351,504	7,705	319	618,695	3,978,223	1,134,462	3.00
4.00	Occupational Therapy	436,185	818	33	64,945	501,981	143,149	4.00
5.00	Speech Pathology	49,750	36	1	3,383	53,170	15,162	5.00
6.00	Medical Social Services	226,079	563	23	45,511	272,176	77,616	6.00
7.00	Home Health Aide	143,445	73	4	5,957	149,479	42,627	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	8,083,516	24,679	1,021	1,979,695	10,088,911	2,877,035	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.					0.000000		21.00
Cost Center Description	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA		
	6.00	7.00	8.00	9.00	10.00	11.00		
1.00	Administrative and General	9,833	3,197	0	3,883	0	21,483	1.00
2.00	Skilled Nursing Care	16,596	5,394	0	6,554	0	36,378	2.00
3.00	Physical Therapy	13,152	4,276	0	5,194	0	28,840	3.00
4.00	Occupational Therapy	1,396	454	0	551	0	3,027	4.00
5.00	Speech Pathology	62	20	0	25	0	157	5.00
6.00	Medical Social Services	962	313	0	380	0	2,122	6.00
7.00	Home Health Aide	124	40	0	49	0	278	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	42,125	13,694	0	16,636	0	92,285	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.

(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS		Provider CCN: 15-0090	Period: From 01/01/2023	Worksheet H-2
		HHA CCN: 15-7145	To 12/31/2023	Part I
				Date/Time Prepared: 5/30/2024 3:45 pm
			Home Health Agency I	PPS

Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES	
	13.00	14.00	15.00	16.00	17.00	21.00	
1.00	Administrative and General	24,307	24,385	0	7,076	0	1.00
2.00	Skilled Nursing Care	41,175	41,296	0	11,982	0	2.00
3.00	Physical Therapy	32,642	32,742	0	9,500	0	3.00
4.00	Occupational Therapy	3,427	3,438	0	997	0	4.00
5.00	Speech Pathology	175	180	0	52	0	5.00
6.00	Medical Social Services	2,402	2,408	0	699	0	6.00
7.00	Home Health Aide	315	315	0	91	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	19.00
19.50	Tel emedicine	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	104,443	104,764	0	30,397	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.						21.00

Cost Center Description	INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS APPRV	PARAMED PRGM - EMERGENCY MEDICINE	PARAMED PRGM- LAB	PARAMED PRGM- PHARMACY	PARAMED PRGM- RADIOLOGY	Subtotal	
	22.00	23.00	23.01	23.02	23.03	24.00	
1.00	Administrative and General	0	0	0	0	694,123	1.00
2.00	Skilled Nursing Care	0	0	0	0	6,157,317	2.00
3.00	Physical Therapy	0	0	0	0	5,239,031	3.00
4.00	Occupational Therapy	0	0	0	0	658,420	4.00
5.00	Speech Pathology	0	0	0	0	69,003	5.00
6.00	Medical Social Services	0	0	0	0	359,078	6.00
7.00	Home Health Aide	0	0	0	0	193,318	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	19.00
19.50	Tel emedicine	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	0	0	0	0	13,370,290	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.						21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.

(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS		Provider CCN: 15-0090	Period: From 01/01/2023	Worksheet H-2 Part I
		HHA CCN: 15-7145	To 12/31/2023	Date/Time Prepared: 5/30/2024 3:45 pm
			Home Health Agency I	PPS

Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	Allocated HHA A&G (see Part II)	Total HHA Costs		
	25.00	26.00	27.00	28.00		
1.00 Administrative and General	0	694,123				1.00
2.00 Skilled Nursing Care	0	6,157,317	337,164	6,494,481		2.00
3.00 Physical Therapy	0	5,239,031	286,879	5,525,910		3.00
4.00 Occupational Therapy	0	658,420	36,054	694,474		4.00
5.00 Speech Pathology	0	69,003	3,778	72,781		5.00
6.00 Medical Social Services	0	359,078	19,662	378,740		6.00
7.00 Home Health Aide	0	193,318	10,586	203,904		7.00
8.00 Supplies (see instructions)	0	0	0	0		8.00
9.00 Drugs	0	0	0	0		9.00
10.00 DME	0	0	0	0		10.00
11.00 Home Dialysis Aide Services	0	0	0	0		11.00
12.00 Respiratory Therapy	0	0	0	0		12.00
13.00 Private Duty Nursing	0	0	0	0		13.00
14.00 Clinic	0	0	0	0		14.00
15.00 Health Promotion Activities	0	0	0	0		15.00
16.00 Day Care Program	0	0	0	0		16.00
17.00 Home Delivered Meals Program	0	0	0	0		17.00
18.00 Homemaker Service	0	0	0	0		18.00
19.00 All Others (specify)	0	0	0	0		19.00
19.50 Telemedicine	0	0	0	0		19.50
20.00 Total (sum of lines 1-19) (2)	0	13,370,290	694,123	13,370,290		20.00
21.00 Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.			0.054758			21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.

(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 15-0090

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

Worksheet H-2 Part II

HHA CCN: 15-7145

Date/Time Prepared: 5/30/2024 3:45 pm

Home Health Agency I

PPS

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES ADJ)	Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)					
	1.00	2.00					
1.00 Administrative and General	317	193	1,645,810	0	466,833	317	1.00
2.00 Skilled Nursing Care	535	328	2,786,981	0	4,667,049	535	2.00
3.00 Physical Therapy	424	260	2,209,587	0	3,978,223	424	3.00
4.00 Occupational Therapy	45	27	231,943	0	501,981	45	4.00
5.00 Speech Pathology	2	1	12,082	0	53,170	2	5.00
6.00 Medical Social Services	31	19	162,536	0	272,176	31	6.00
7.00 Home Health Aide	4	3	21,273	0	149,479	4	7.00
8.00 Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00 Drugs	0	0	0	0	0	0	9.00
10.00 DME	0	0	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	0	0	0	12.00
13.00 Private Duty Nursing	0	0	0	0	0	0	13.00
14.00 Clinic	0	0	0	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	0	0	0	15.00
16.00 Day Care Program	0	0	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00 Homemaker Service	0	0	0	0	0	0	18.00
19.00 All Others (specify)	0	0	0	0	0	0	19.00
19.50 Telemedicine	0	0	0	0	0	0	19.50
20.00 Total (sum of lines 1-19)	1,358	831	7,070,212		10,088,911	1,358	20.00
21.00 Total cost to be allocated	24,679	1,021	1,979,695		2,877,035	42,125	21.00
22.00 Unit cost multiplier	18.173049	1.228640	0.280005		0.285168	31.019882	22.00
Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUND)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT MEALS)	CAFETERIA (HOURS WORKED)	NURSING ADMINISTRATION (DIRECT NRSING)	
	7.00	8.00	9.00	10.00	11.00	13.00	
1.00 Administrative and General	317	0	317	0	14,476	2,085	1.00
2.00 Skilled Nursing Care	535	0	535	0	24,513	3,532	2.00
3.00 Physical Therapy	424	0	424	0	19,434	2,800	3.00
4.00 Occupational Therapy	45	0	45	0	2,040	294	4.00
5.00 Speech Pathology	2	0	2	0	106	15	5.00
6.00 Medical Social Services	31	0	31	0	1,430	206	6.00
7.00 Home Health Aide	4	0	4	0	187	27	7.00
8.00 Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00 Drugs	0	0	0	0	0	0	9.00
10.00 DME	0	0	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	0	0	0	12.00
13.00 Private Duty Nursing	0	0	0	0	0	0	13.00
14.00 Clinic	0	0	0	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	0	0	0	15.00
16.00 Day Care Program	0	0	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00 Homemaker Service	0	0	0	0	0	0	18.00
19.00 All Others (specify)	0	0	0	0	0	0	19.00
19.50 Telemedicine	0	0	0	0	0	0	19.50
20.00 Total (sum of lines 1-19)	1,358	0	1,358	0	62,186	8,959	20.00
21.00 Total cost to be allocated	13,694	0	16,636	0	92,285	104,443	21.00
22.00 Unit cost multiplier	10.083947	0.000000	12.250368	0.000000	1.484016	11.657886	22.00



ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS		Provider CCN: 15-0090 HHA CCN: 15-7145	Period: From 01/01/2023 To 12/31/2023	Worksheet H-2 Part II Date/Time Prepared: 5/30/2024 3:45 pm PPS
			Home Health Agency I	

Cost Center Description	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICES (GROSS CHARGES)	I INTERNS & RESIDENTS	SERVICES-SALARY & FRINGES (ASSIGNED TIME)	SERVICES-OTHER PRGM COSTS APPRV (ASSIGNED TIME)	
	14.00	15.00	16.00	17.00		21.00	22.00	
1.00	Administrative and General	8,830	0	2,406,730	2,406,730	0	0	1.00
2.00	Skilled Nursing Care	14,954	0	4,075,507	4,075,507	0	0	2.00
3.00	Physical Therapy	11,856	0	3,231,162	3,231,162	0	0	3.00
4.00	Occupational Therapy	1,245	0	339,179	339,179	0	0	4.00
5.00	Speech Pathology	65	0	17,668	17,668	0	0	5.00
6.00	Medical Social Services	872	0	237,682	237,682	0	0	6.00
7.00	Home Health Aide	114	0	31,108	31,108	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Tel emedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	37,936	0	10,339,036	10,339,036	0	0	20.00
21.00	Total cost to be allocated	104,764	0	30,397	0	0	0	21.00
22.00	Unit cost multiplier	2.761598	0.000000	0.002940	0.000000	0.000000	0.000000	22.00
Cost Center Description	PARAMED ED PRGM - EMERGENCY MEDICINE (ASSIGNED TIME)	PARAMED ED PRGM- LAB (ASSIGNED TIME)	PARAMED ED PRGM- PHARMACY (ASSIGNED TIME)	PARAMED ED PRGM- RADIOLOGY (ASSIGNED TIME)				
	23.00	23.01	23.02	23.03				
1.00	Administrative and General	0	0	0	0			1.00
2.00	Skilled Nursing Care	0	0	0	0			2.00
3.00	Physical Therapy	0	0	0	0			3.00
4.00	Occupational Therapy	0	0	0	0			4.00
5.00	Speech Pathology	0	0	0	0			5.00
6.00	Medical Social Services	0	0	0	0			6.00
7.00	Home Health Aide	0	0	0	0			7.00
8.00	Supplies (see instructions)	0	0	0	0			8.00
9.00	Drugs	0	0	0	0			9.00
10.00	DME	0	0	0	0			10.00
11.00	Home Dialysis Aide Services	0	0	0	0			11.00
12.00	Respiratory Therapy	0	0	0	0			12.00
13.00	Private Duty Nursing	0	0	0	0			13.00
14.00	Clinic	0	0	0	0			14.00
15.00	Health Promotion Activities	0	0	0	0			15.00
16.00	Day Care Program	0	0	0	0			16.00
17.00	Home Delivered Meals Program	0	0	0	0			17.00
18.00	Homemaker Service	0	0	0	0			18.00
19.00	All Others (specify)	0	0	0	0			19.00
19.50	Tel emedicine	0	0	0	0			19.50
20.00	Total (sum of lines 1-19)	0	0	0	0			20.00
21.00	Total cost to be allocated	0	0	0	0			21.00
22.00	Unit cost multiplier	0.000000	0.000000	0.000000	0.000000			22.00

APPORTIONMENT OF PATIENT SERVICE COSTS				Provider CCN: 15-0090 HHA CCN: 15-7145		Period: From 01/01/2023 To 12/31/2023		Worksheet H-3 Part I Date/Time Prepared: 5/30/2024 3:45 pm	
				Title XVIII		Home Health Agency I		PPS	
Cost Center Description		From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (col. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 + col. 4)		
		0	1.00	2.00	3.00	4.00	5.00		
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION									
Cost Per Visit Computation									
1.00	Skilled Nursing Care	2.00	6,494,481		6,494,481	24,971	260.08		1.00
2.00	Physical Therapy	3.00	5,525,910	0	5,525,910	25,296	218.45		2.00
3.00	Occupational Therapy	4.00	694,474	0	694,474	4,067	170.76		3.00
4.00	Speech Pathology	5.00	72,781	0	72,781	494	147.33		4.00
5.00	Medical Social Services	6.00	378,740		378,740	44	8,607.73		5.00
6.00	Home Health Aide	7.00	203,904		203,904	1,605	127.04		6.00
7.00	Total (sum of lines 1-6)		13,370,290	0	13,370,290	56,477			7.00
				Program Visits					
				Part B					
				Not Subject to Deductibles & Coinsurance		Subject to Deductibles			
		0	1.00	2.00	3.00	4.00	5.00		
Limitation Cost Computation									
8.00	Skilled Nursing Care		16984	0	45				8.00
8.01	Skilled Nursing Care		23844	0	6,985				8.01
8.02	Skilled Nursing Care		33140	0	3,129				8.02
8.03	Skilled Nursing Care		43780	0	3				8.03
8.04	Skilled Nursing Care		99915	0	0				8.04
9.00	Physical Therapy		16984	0	21				9.00
9.01	Physical Therapy		23844	0	7,052				9.01
9.02	Physical Therapy		33140	0	3,496				9.02
9.03	Physical Therapy		43780	0	7				9.03
9.04	Physical Therapy		99915	0	17				9.04
10.00	Occupational Therapy		16984	0	0				10.00
10.01	Occupational Therapy		23844	0	1,098				10.01
10.02	Occupational Therapy		33140	0	707				10.02
10.03	Occupational Therapy		43780	0	5				10.03
10.04	Occupational Therapy		99915	0	0				10.04
11.00	Speech Pathology		16984	0	0				11.00
11.01	Speech Pathology		23844	0	166				11.01
11.02	Speech Pathology		33140	0	12				11.02
11.03	Speech Pathology		43780	0	0				11.03
11.04	Speech Pathology		99915	0	0				11.04
12.00	Medical Social Services		16984	0	0				12.00
12.01	Medical Social Services		23844	0	15				12.01
12.02	Medical Social Services		33140	0	0				12.02
12.03	Medical Social Services		43780	0	0				12.03
12.04	Medical Social Services		99915	0	0				12.04
13.00	Home Health Aide		16984	0	0				13.00
13.01	Home Health Aide		23844	0	776				13.01
13.02	Home Health Aide		33140	0	275				13.02
13.03	Home Health Aide		43780	0	0				13.03
13.04	Home Health Aide		99915	0	0				13.04
14.00	Total (sum of lines 8-13)			0	23,809				14.00
Cost Center Description		From Wkst. H-2 Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (col. 1 + 2)	Total Charges (from HHA Records)	Ratio (col. 3 + col. 4)		
		0	1.00	2.00	3.00	4.00	5.00		
Supplies and Drugs Cost Computations									
15.00	Cost of Medical Supplies	8.00	0	0	0	0	0.000000		15.00
16.00	Cost of Drugs	9.00	0	0	0	0	0.000000		16.00

APPORTIONMENT OF PATIENT SERVICE COSTS		Provider CCN: 15-0090	Period: From 01/01/2023	Worksheet H-3
		HHA CCN: 15-7145	To 12/31/2023	Part I Date/Time Prepared: 5/30/2024 3:45 pm
		Title XVIII	Home Health Agency I	PPS

Cost Center Description	Program Visits			Cost of Services			
	Part A	Part B		Part A	Part B		
		Not Subject to Deductibles & Coi nsurance	Subject to Deductibles & Coi nsurance		Not Subject to Deductibles & Coi nsurance		Subject to Deductibles & Coi nsurance
	6.00	7.00	8.00	9.00	10.00	11.00	

PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
Cost Per Visit Computation							
1.00	Skilled Nursing Care	0	10,162		0	2,642,933	1.00
2.00	Physical Therapy	0	10,593		0	2,314,041	2.00
3.00	Occupational Therapy	0	1,810		0	309,076	3.00
4.00	Speech Pathology	0	178		0	26,225	4.00
5.00	Medical Social Services	0	15		0	129,116	5.00
6.00	Home Health Aide	0	1,051		0	133,519	6.00
7.00	Total (sum of lines 1-6)	0	23,809		0	5,554,910	7.00
Cost Center Description							
		6.00	7.00	8.00	9.00	10.00	11.00

Limitation Cost Computation							
8.00	Skilled Nursing Care						8.00
8.01	Skilled Nursing Care						8.01
8.02	Skilled Nursing Care						8.02
8.03	Skilled Nursing Care						8.03
8.04	Skilled Nursing Care						8.04
9.00	Physical Therapy						9.00
9.01	Physical Therapy						9.01
9.02	Physical Therapy						9.02
9.03	Physical Therapy						9.03
9.04	Physical Therapy						9.04
10.00	Occupational Therapy						10.00
10.01	Occupational Therapy						10.01
10.02	Occupational Therapy						10.02
10.03	Occupational Therapy						10.03
10.04	Occupational Therapy						10.04
11.00	Speech Pathology						11.00
11.01	Speech Pathology						11.01
11.02	Speech Pathology						11.02
11.03	Speech Pathology						11.03
11.04	Speech Pathology						11.04
12.00	Medical Social Services						12.00
12.01	Medical Social Services						12.01
12.02	Medical Social Services						12.02
12.03	Medical Social Services						12.03
12.04	Medical Social Services						12.04
13.00	Home Health Aide						13.00
13.01	Home Health Aide						13.01
13.02	Home Health Aide						13.02
13.03	Home Health Aide						13.03
13.04	Home Health Aide						13.04
14.00	Total (sum of lines 8-13)						14.00

Cost Center Description	Program Covered Charges			Cost of Services			
	Part A	Part B		Part A	Part B		
		Not Subject to Deductibles & Coi nsurance	Subject to Deductibles & Coi nsurance		Not Subject to Deductibles & Coi nsurance		Subject to Deductibles & Coi nsurance
	6.00	7.00	8.00	9.00	10.00	11.00	

Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies	0	147,755	0	0	0	15.00
16.00	Cost of Drugs		0	0		0	16.00

APPORTIONMENT OF PATIENT SERVICE COSTS		Provider CCN: 15-0090 HHA CCN: 15-7145	Period: From 01/01/2023 To 12/31/2023	Worksheet H-3 Part I Date/Time Prepared: 5/30/2024 3:45 pm
		Title XVIII	Home Health Agency I	PPS

Cost Center Description	Total Program Cost (sum of col.s. 9-10)		
		12.00	
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION			
Cost Per Visit Computation			
1.00	Skilled Nursing Care	2,642,933	1.00
2.00	Physical Therapy	2,314,041	2.00
3.00	Occupational Therapy	309,076	3.00
4.00	Speech Pathology	26,225	4.00
5.00	Medical Social Services	129,116	5.00
6.00	Home Health Aide	133,519	6.00
7.00	Total (sum of lines 1-6)	5,554,910	7.00
Cost Center Description		12.00	
Limitation Cost Computation			
8.00	Skilled Nursing Care		8.00
8.01	Skilled Nursing Care		8.01
8.02	Skilled Nursing Care		8.02
8.03	Skilled Nursing Care		8.03
8.04	Skilled Nursing Care		8.04
9.00	Physical Therapy		9.00
9.01	Physical Therapy		9.01
9.02	Physical Therapy		9.02
9.03	Physical Therapy		9.03
9.04	Physical Therapy		9.04
10.00	Occupational Therapy		10.00
10.01	Occupational Therapy		10.01
10.02	Occupational Therapy		10.02
10.03	Occupational Therapy		10.03
10.04	Occupational Therapy		10.04
11.00	Speech Pathology		11.00
11.01	Speech Pathology		11.01
11.02	Speech Pathology		11.02
11.03	Speech Pathology		11.03
11.04	Speech Pathology		11.04
12.00	Medical Social Services		12.00
12.01	Medical Social Services		12.01
12.02	Medical Social Services		12.02
12.03	Medical Social Services		12.03
12.04	Medical Social Services		12.04
13.00	Home Health Aide		13.00
13.01	Home Health Aide		13.01
13.02	Home Health Aide		13.02
13.03	Home Health Aide		13.03
13.04	Home Health Aide		13.04
14.00	Total (sum of lines 8-13)		14.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 15-0090

Period: From 01/01/2023

Worksheet H-3

HHA CCN: 15-7145

To 12/31/2023

Part II  
Date/Time Prepared:  
5/30/2024 3:45 pm

Home Health  
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PPS

Cost Center Description	From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated		
	0	1.00	2.00	3.00	4.00		
<b>PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS</b>							
1.00 Physical Therapy	66.00	0.251568	0	0	col. 2, line 2.00		1.00
2.00 Occupational Therapy	67.00	0.092473	0	0	col. 2, line 3.00		2.00
3.00 Speech Pathology	68.00	0.143394	0	0	col. 2, line 4.00		3.00
4.00 Cost of Medical Supplies	71.00	0.327634	0	0	col. 2, line 15.00		4.00
5.00 Cost of Drugs	73.00	0.276036	0	0	col. 2, line 16.00		5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0090 HHA CCN: 15-7145	Period: From 01/01/2023 To 12/31/2023	Worksheet H-4 Part I-11 Date/Time Prepared: 5/30/2024 3:45 pm
		Title XVIII	Home Health Agency I	PPS
		Part A	Part B	
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance
		1.00	2.00	3.00
<b>PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES</b>				
Reasonable Cost of Part A & Part B Services				
1.00	Reasonable cost of services (see instructions)	0	0	0
2.00	Total charges	0	0	0
Customary Charges				
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)	0	0	0
4.00	Amount 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(b)	0	0	0
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	0.000000
6.00	Total customary charges (see instructions)	0	0	0
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	0	0	0
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	0	0
9.00	Primary payer amounts	0	0	0
			Part A Services	Part B Services
			1.00	2.00
<b>PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT</b>				
10.00	Total reasonable cost (see instructions)		0	0
11.00	Total PPS Reimbursement - Full Episodes without Outliers		0	5,113,677
12.00	Total PPS Reimbursement - Full Episodes with Outliers		0	481,016
13.00	Total PPS Reimbursement - LUPA Episodes		0	52,003
14.00	Total PPS Reimbursement - PEP Episodes		0	8,614
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers		0	127,700
16.00	Total PPS Outlier Reimbursement - PEP Episodes		0	401
17.00	Total Other Payments		0	0
18.00	DME Payments		0	0
19.00	Oxygen Payments		0	0
20.00	Prosthetic and Orthotic Payments		0	0
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)		0	0
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)		0	5,783,411
23.00	Excess reasonable cost (from line 8)		0	0
24.00	Subtotal (line 22 minus line 23)		0	5,783,411
25.00	Coinsurance billed to program patients (from your records)		0	0
26.00	Net cost (line 24 minus line 25)		0	5,783,411
27.00	Allowable bad debts (from your records)		0	0
27.01	Adjusted reimbursable bad debts (see instructions)		0	0
28.00	Allowable bad debts for dual eligible (see instructions)		0	0
29.00	Total costs - current cost reporting period (see instructions)		0	5,783,411
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0
30.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	0
30.99	Demonstration payment adjustment amount before sequestration		0	0
31.00	Subtotal (see instructions)		0	5,783,411
31.01	Sequestration adjustment (see instructions)		0	115,666
31.02	Demonstration payment adjustment after sequestration		0	0
31.75	Sequestration adjustment for non-claims based amounts (see instructions)		0	0
32.00	Interim payments (see instructions)		0	5,667,745
33.00	Tentative settlement (for contractor use only)		0	0
34.00	Balance due provider/program (line 31 minus lines 31.01, 31.02, 31.75, 32, and 33)		0	0
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	0

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED HHAs FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 15-0090	Period: From 01/01/2023 To 12/31/2023	Worksheet H-5
	HHA CCN: 15-7145	Home Health Agency I	Date/Time Prepared: 5/30/2024 3:45 pm PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		0		5,667,745	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
<b>Program to Provider</b>						
3.01			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
<b>Provider to Program</b>						
3.50			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. H-4, Part II, column as appropriate, line 32)		0		5,667,745	4.00
<b>TO BE COMPLETED BY CONTRACTOR</b>						
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
<b>Program to Provider</b>						
5.01			0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
<b>Provider to Program</b>						
5.50			0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		0		5,667,745	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
				0	1.00	2.00
8.00	Name of Contractor					8.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 15-0090	Period: From 01/01/2023 To 12/31/2023	Worksheet L Parts I-III Date/Time Prepared: 5/30/2024 3:45 pm
		Title XVIII	Hospital	PPS
				1.00
<b>PART I - FULLY PROSPECTIVE METHOD</b>				
<b>CAPITAL FEDERAL AMOUNT</b>				
1.00	Capital DRG other than outlier		1,422,103	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		29,968	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)		75.82	3.00
4.00	Number of interns & residents (see instructions)		4.81	4.00
5.00	Indirect medical education percentage (see instructions)		1.81	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)		25,740	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30)(see instructions)		4.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		28.68	8.00
9.00	Sum of lines 7 and 8		32.68	9.00
10.00	Allowable disproportionate share percentage (see instructions)		6.84	10.00
11.00	Disproportionate share adjustment (see instructions)		97,272	11.00
12.00	Total prospective capital payments (see instructions)		1,575,083	12.00
				1.00
<b>PART II - PAYMENT UNDER REASONABLE COST</b>				
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
<b>PART III - COMPUTATION OF EXCEPTION PAYMENTS</b>				
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