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: 15-0057	Period: From 01/01/2023 To 12/31/2023	Worksheet S Parts I-III Date/Time Prepared: 5/31/2024 10:46 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 5/31/2024 Time: 10:46 am
2. [ ] Manually prepared cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no.

Contractor use only

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

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

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by FRANCISCAN HEALTH MOORESVILLE (15-0057) 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	Jay Brehm		Y	I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name	Jay Brehm			2
3	Signatory Title	REGIONAL CFO			3
4	Date	(Dated when report is electronica			4

		Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	HOSPITAL	0	561,691	-3,724	0	0	1.00
2.00	SUBPROVIDER - IPF	0	0	0		0	2.00
3.00	SUBPROVIDER - IRF	0	0	0		0	3.00
5.00	SWING BED - SNF	0	0	0		0	5.00
6.00	SWING BED - NF	0				0	6.00
200.00	TOTAL	0	561,691	-3,724	0	0	200.00

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

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The number for this information collection is OMB 0938-0050 and the number for the Supplement to Form CMS 2552-10, Worksheet N95, is OMB 0938-1425. The time required to complete and review the information collection is estimated 675 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.
Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0057 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I | Date/Time Prepared: 5/31/2024 10:46 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 1201 HADLEY ROAD	PO Box:			1.00
2.00	City: MOORESVILLE	State: IN	Zip Code: 46158	County:	2.00

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	FRANCISCAN HEALTH MOORESVILLE	150057	26900	1	07/01/1996	N	P	P	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	01/01/2023	12/31/2023	20.00
21.00	Type of Control (see instructions)	2		21.00

		1.00	2.00	3.00	
	Inpatient PPS Information				
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	Y	N		22.00
22.01	Did this hospital receive interim UCPs, including supplemental UCPs, for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	Y	Y		22.01
22.02	Is this a newly merged hospital that requires a final UCP to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N		22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.	N	N	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: 15-0057 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I | Date/Time Prepared: 5/31/2024 10:46 am

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	38	5	0	0	1,731	69	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00

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

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

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

		V	XVIII	XIX	
		1.00	2.00	3.00	
	Prospective Payment System (PPS)-Capital				
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y for yes or "N" for no.	N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00
	Teaching Hospitals				
56.00	Is this a hospital involved in training residents in approved GME programs? For cost reporting periods beginning prior to December 27, 2020, enter "Y" for yes or "N" for no in column 1. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.78(b)(2), see the instructions. For column 2, if the response to column 1 is "Y", or if this hospital was involved in training residents in approved GME programs in the prior year or penultimate year, and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter "Y" for yes; otherwise, enter "N" for no in column 2.	N	N		56.00
57.00	For cost reporting periods beginning prior to December 27, 2020, if line 56, column 1, is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.77(e)(1)(iv) and (v), regardless of which month(s) of the cost report the residents were on duty, if the response to line 56 is "Y" for yes, enter "Y" for yes in column 1, do not complete column 2, and complete Worksheet E-4.	N			57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.	N			58.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0057 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I Date/Time Prepared: 5/31/2024 10:46 am

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0057 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I Date/Time Prepared: 5/31/2024 10:46 am

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0057 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I Date/Time Prepared: 5/31/2024 10:46 am

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

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

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

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

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

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	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: 15-0057 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I Date/Time Prepared: 5/31/2024 10:46 am

		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
	Rural Providers			
105.00	Does this hospital qualify as a CAH?	N		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N		106.00
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N		107.00
107.01	If this facility is a REH (line 3, column 4, is "12"), is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no. (see instructions)			107.01
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

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

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

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

		1.00	2.00	3.00	
112.00	Did this hospital participate in the Pennsylvania Rural Health Model (PARHM) demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N			112.00
	Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	N			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: 15-0057 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I | Date/Time Prepared: 5/31/2024 10:46 am

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	0	123,000	300,860	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	Y	5.03	122.00
123.00	Did the facility and/or its subproviders (if applicable) purchase professional services, e.g., legal, accounting, tax preparation, bookkeeping, payroll, and/or management/consulting services, from an unrelated organization? In column 1, enter "Y" for yes or "N" for no. If column 1 is "Y", were the majority of the expenses, i.e., greater than 50% of total professional services expenses, for services purchased from unrelated organizations located in a CBSA outside of the main hospital CBSA? In column 2, enter "Y" for yes or "N" for no.	Y		123.00
	Certified Transplant Center Information			
125.00	Does this facility operate a Medicare-certified transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare-certified kidney transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare-certified heart transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare-certified liver transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare-certified lung transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare-certified pancreas transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare-certified intestinal transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare-certified islet transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	Removed and reserved			133.00
134.00	If this is a hospital-based organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	158014	140.00

	1.00	2.00	3.00	
	If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.			
141.00	Name: FRANCISCAN ALLIANCE INC. AND AFFILI	Contractor's Name: WISCONSIN PHYSICIANS SERVICE	Contractor's Number: 08101	141.00
142.00	Street: 1515 W DRAGOON TRL	PO Box: 1290		142.00
143.00	City: MISHAWAKA	State: IN	Zip Code: 46544	143.00

		1.00	
144.00	Are provider based physicians' costs included in Worksheet A?	Y	144.00

		1.00	2.00	
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.			145.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N		146.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-0057	Period: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part I Date/Time Prepared: 5/31/2024 10:46 am

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

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

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

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

		1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act		
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.	Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)		168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)		168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	9.99	169.00

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			170.00

		1.00	2.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)	N	0	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-0057 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part II | Date/Time Prepared: 5/31/2024 10:46 am

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

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

		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	04/25/2024	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00

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

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	N		N		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	04/09/2024	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: 15-0057 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part II Date/Time Prepared: 5/31/2024 10:46 am

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

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

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

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	PAM	MEISER	41.00
42.00	Enter the employer/company name of the cost report preparer.	FRANCISCAN HEALTH		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	734-777-7602	PAMELA.MEISER@FRANCISCANALLIANCE.ORG	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-0057	Period: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part II Date/Time Prepared: 5/31/2024 10:46 am

		3.00		
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	COST REPORTING 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: 15-0057 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part I | Date/Time Prepared: 5/31/2024 10:46 am

	Component	Worksheet A Line No.	No. of Beds	Bed Days Available	CAH/REH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	70	25,550	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)		70	25,550	0.00	0	7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT	34.00	10	3,650	0.00	0	11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		80	29,200	0.00	0	14.00
15.00	CAH visits					0	15.00
15.10	REH hours and visits				0.00	0	15.10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		80				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: 15-0057 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part I | Date/Time Prepared: 5/31/2024 10:46 am

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	1,957	33	5,888			1.00
2.00	HMO and other (see instructions)	169	1,730				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,957	33	5,888			7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT	381	7	1,307			11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY		4	632			13.00
14.00	Total (see instructions)	2,338	44	7,827	0.00	307.15	14.00
15.00	CAH visits	0	0	0			15.00
15.10	REH hours and visits	0	0	0			15.10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	307.15	27.00
28.00	Observation Bed Days		234	1,442			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	69	110			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: 15-0057 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part I | Date/Time Prepared: 5/31/2024 10:46 am

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	727	15	2,307	1.00
2.00	HMO and other (see instructions)			47	607		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	727	15	2,307	14.00
15.00	CAH visits						15.00
15.10	REH hours and visits						15.10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care						34.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0057 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part II | Date/Time Prepared: 5/31/2024 10:46 am

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	25,559,496	0	25,559,496	650,143.00	39.31	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician and Non Physician-Part B		172,056	0	172,056	10.00	17,205.60	5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		296,307	209,103	505,410	14,853.00	34.03	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		4,108,107	0	4,108,107	39,813.00	103.19	11.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		44,750	0	44,750	422.00	106.04	13.00
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00	14.00
14.01	Home office salaries		13,192,733	0	13,192,733	395,284.00	33.38	14.01
14.02	Related organization salaries		0	0	0	0.00	0.00	14.02
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
16.01	Home office Physicians Part A - Teaching		0	0	0	0.00	0.00	16.01
16.02	Home office contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.02
	WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		6,029,621	-49,329	5,980,292			17.00
18.00	Wage-related costs (other) (see instructions)							18.00
19.00	Excluded areas		131,519	49,329	180,848			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		0	0	0			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		21,355	0	21,355			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
25.50	Home office wage-related (core)		4,009,196	0	4,009,196			25.50
25.51	Related organization wage-related (core)		0	0	0			25.51
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0			25.52

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0057 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part II | Date/Time Prepared: 5/31/2024 10:46 am

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
25.53	Home office: Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	278,046	-209,103	68,943	2,046.00	33.70	26.00
27.00	Administrative & General	5.00	734,936	0	734,936	21,423.00	34.31	27.00
28.00	Administrative & General under contract (see inst.)		624,478	0	624,478	5,294.00	117.96	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	1,216,518	0	1,216,518	40,436.00	30.09	30.00
31.00	Laundry & Linen Service	8.00	54,511	0	54,511	3,112.00	17.52	31.00
32.00	Housekeeping	9.00	1,231,242	0	1,231,242	63,273.00	19.46	32.00
33.00	Housekeeping under contract (see instructions)		9,240	0	9,240	269.00	34.35	33.00
34.00	Dietary	10.00	453,802	-322,884	130,918	6,137.00	21.33	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	39,577	322,884	362,461	17,215.00	21.05	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	612,129	0	612,129	9,932.00	61.63	38.00
39.00	Central Services and Supply	14.00	150,386	0	150,386	6,292.00	23.90	39.00
40.00	Pharmacy	15.00	969,185	0	969,185	20,622.00	47.00	40.00
41.00	Medical Records & Medical Records Library	16.00	0	0	0	0.00	0.00	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0057 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part III Date/Time Prepared: 5/31/2024 10:46 am

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)		26,021,158	0	26,021,158	655,696.00	39.68	1.00
2.00	Excluded area salaries (see instructions)		296,307	209,103	505,410	14,853.00	34.03	2.00
3.00	Subtotal salaries (line 1 minus line 2)		25,724,851	-209,103	25,515,748	640,843.00	39.82	3.00
4.00	Subtotal other wages & related costs (see inst.)		17,345,590	0	17,345,590	435,519.00	39.83	4.00
5.00	Subtotal wage-related costs (see inst.)		10,038,817	-49,329	9,989,488	0.00	39.15	5.00
6.00	Total (sum of lines 3 thru 5)		53,109,258	-258,432	52,850,826	1,076,362.00	49.10	6.00
7.00	Total overhead cost (see instructions)		6,374,050	-209,103	6,164,947	196,051.00	31.45	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 15-0057 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part IV | Date/Time Prepared: 5/31/2024 10:46 am

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	818,916	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)	611,686	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	2,609,336	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	93,269	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	8,381	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	25	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	88,884	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	8,180	14.00
15.00	'Workers' Compensation Insurance	208,981	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Noncumulative portion)	0	16.00
	TAXES		
17.00	FICA-Employers Portion Only	1,734,859	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	0	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	6,182,517	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)		25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST | Provider CCN: 15-0057 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part V | Date/Time Prepared: 5/31/2024 10:46 am

	Cost Center Description	Contract Labor	Benefit Cost	
		1.00	2.00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	4,108,107	6,182,517	1.00
2.00	Hospital	4,108,107	6,182,517	2.00
3.00	SUBPROVIDER - IPF			3.00
4.00	SUBPROVIDER - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	SKILLED NURSING FACILITY			8.00
9.00	NURSING FACILITY			9.00
10.00	OTHER LONG TERM CARE I			10.00
11.00	Hospital-Based HHA			11.00
12.00	AMBULATORY SURGICAL CENTER (D.P.) I			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	RENAL DIALYSIS I	0	0	17.00
18.00	Other	0	0	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 15-0057	Period: From 01/01/2023 To 12/31/2023	Worksheet S-10 Parts I & II Date/Time Prepared: 5/31/2024 10:46 am

		1.00	
	PART I - HOSPITAL AND HOSPITAL COMPLEX DATA		
	Uncompensated and Indigent Care Cost-to-Charge Ratio		
1.00	Cost to charge ratio (see instructions)	0.159523	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	18,420,708	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	109,853,530	6.00
7.00	Medicaid cost (line 1 times line 6)	17,524,165	7.00
8.00	Difference between net revenue and costs for Medicaid program (see instructions)	0	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	0	9.00
10.00	Stand-alone CHIP charges	0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (see instructions)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (see instructions)	0	16.00
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	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)	0	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
	Uncompensated care cost (see instructions for each line)				
20.00	Charity care charges and uninsured discounts (see instructions)	11,745,798	3,655,941	15,401,739	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	1,873,725	3,655,941	5,529,666	21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0	22.00
23.00	Cost of charity care (see instructions)	1,873,725	3,655,941	5,529,666	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)	3,746,882	26.00
27.00	Medicare reimbursable bad debts (see instructions)	127,088	27.00
27.01	Medicare allowable bad debts (see instructions)	195,520	27.01
28.00	Non-Medicare bad debt amount (see instructions)	3,551,362	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)	634,956	29.00
30.00	Cost of uncompensated care (line 23, col. 3, plus line 29)	6,164,622	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	6,164,622	31.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 15-0057	Period: From 01/01/2023 To 12/31/2023	Worksheet S-10 Parts I & II Date/Time Prepared: 5/31/2024 10:46 am

		1.00	
	PART II - HOSPITAL DATA		
	Uncompensated and Indigent Care Cost-to-Charge Ratio		
1.00	Cost to charge ratio (see instructions)	0.159523	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid		2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?		4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid		5.00
6.00	Medicaid charges		6.00
7.00	Medicaid cost (line 1 times line 6)		7.00
8.00	Difference between net revenue and costs for Medicaid program (see instructions)		8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP		9.00
10.00	Stand-alone CHIP charges		10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)		11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (see instructions)		12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)		13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		14.00
15.00	State or local indigent care program cost (line 1 times line 14)		15.00
16.00	Difference between net revenue and costs for state or local indigent care program (see instructions)		16.00
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care		17.00
18.00	Government grants, appropriations or transfers for support of hospital operations		18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
	Uncompensated care cost (see instructions for each line)				
20.00	Charity care charges and uninsured discounts (see instructions)	0	0	0	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	0	0	0	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)	0	0	0	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)	374,688,223	26.00
27.00	Medicare reimbursable bad debts (see instructions)	127,088	27.00
27.01	Medicare allowable bad debts (see instructions)	195,520	27.01
28.00	Non-Medicare bad debt amount (see instructions)	374,492,703	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)	59,808,631	29.00
30.00	Cost of uncompensated care (line 23, col. 3, plus line 29)	59,808,631	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	59,808,631	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0057 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A | Date/Time Prepared: 5/31/2024 10:46 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		0	0	6,131,307	6,131,307	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	2,334,501	2,334,501	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	278,046	223,581	501,627	-407,110	94,517	4.00
5.01	00570	ADMITTING	0	1,406	1,406	-1,201	205	5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	0	0	0	0	5.02
5.03	00590	OTHER ADMIN & GENERAL	734,936	14,019,876	14,754,812	-3,888,779	10,866,033	5.03
7.00	00700	OPERATION OF PLANT	1,216,518	2,885,639	4,102,157	-195,963	3,906,194	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	54,511	259,164	313,675	-1,069	312,606	8.00
9.00	00900	HOUSEKEEPING	1,231,242	727,336	1,958,578	-33,716	1,924,862	9.00
10.00	01000	DIETARY	453,802	250,027	703,829	-469,369	234,460	10.00
11.00	01100	CAFETERIA	39,577	183,169	222,746	424,848	647,594	11.00
13.00	01300	NURSING ADMINISTRATION	612,129	6,192	618,321	-2,580	615,741	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	150,386	267,676	418,062	-136,901	281,161	14.00
15.00	01500	PHARMACY	969,185	2,218,410	3,187,595	-2,172,669	1,014,926	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,822,937	3,065,266	7,888,203	-2,301,736	5,586,467	30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	1,642,489	398,100	2,040,589	-173,930	1,866,659	34.00
43.00	04300	NURSERY	0	0	0	455,549	455,549	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,122,710	11,207,821	13,330,531	-10,960,148	2,370,383	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,400	757	3,157	1,323,147	1,326,304	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,195,278	1,088,021	3,283,299	-788,981	2,494,318	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	520,743	3,749,082	4,269,825	-748,114	3,521,711	55.00
60.00	06000	LABORATORY	0	3,688,156	3,688,156	-260,154	3,428,002	60.00
64.00	06400	INTRAVENOUS THERAPY	946,457	15,081,297	16,027,754	-14,907,528	1,120,226	64.00
65.00	06500	RESPIRATORY THERAPY	1,174,289	272,586	1,446,875	-264,223	1,182,652	65.00
66.00	06600	PHYSICAL THERAPY	1,612,692	88,864	1,701,556	-71,686	1,629,870	66.00
67.00	06700	OCCUPATIONAL THERAPY	225,318	11,185	236,503	-9,088	227,415	67.00
68.00	06800	SPEECH PATHOLOGY	63,640	1,284	64,924	0	64,924	68.00
69.00	06900	ELECTROCARDIOLOGY	324,345	142,988	467,333	-135,989	331,344	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	13,555	49,173	62,728	-43,477	19,251	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	5,627,502	5,627,502	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	10,383,358	10,383,358	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	16,142,460	16,142,460	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CARE INSTITUTE	8,269	1,169	9,438	-1,169	8,269	90.01
90.02	09002	OP NUTRITIONAL COUNSELING	59,271	417	59,688	-347	59,341	90.02
91.00	09100	EMERGENCY	3,788,464	1,936,613	5,725,077	-479,698	5,245,379	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		-194,543	-194,543	194,543	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	25,263,189	61,630,712	86,893,901	4,561,590	91,455,491	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	42,019	74,075	116,094	0	116,094	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	3,770	1,243	5,013	265,022	270,035	192.00
194.00	07950	COMMUNITY RELATIONS & MARKETING	0	0	0	0	0	194.00
194.01	07951	PLAINFIELD RADIOLOGY & PHYSICAL THE	235,435	209,054	444,489	-198,534	245,955	194.01
194.02	07952	JV MV ENDOSCOPY	0	0	0	0	0	194.02
194.03	07953	SOUTHWEST CENTER FOR WOMENS HEALTH	0	0	0	0	0	194.03
194.04	07954	OTHER NRCC	15,083	23,122,425	23,137,508	-4,628,078	18,509,430	194.04
200.00		TOTAL (SUM OF LINES 118 through 199)	25,559,496	85,037,509	110,597,005	0	110,597,005	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0057 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A | Date/Time Prepared: 5/31/2024 10:46 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	1,349,005	7,480,312		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	876,191	3,210,692		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	6,854,762	6,949,279		4.00
5.01	00570	ADMITTING	0	205		5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	0		5.02
5.03	00590	OTHER ADMIN & GENERAL	11,863,587	22,729,620		5.03
7.00	00700	OPERATION OF PLANT	1,041,716	4,947,910		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	-27,245	285,361		8.00
9.00	00900	HOUSEKEEPING	-12,250	1,912,612		9.00
10.00	01000	DIETARY	-11	234,449		10.00
11.00	01100	CAFETERIA	-312,349	335,245		11.00
13.00	01300	NURSING ADMINISTRATION	61,519	677,260		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-19,958	261,203		14.00
15.00	01500	PHARMACY	107,427	1,122,353		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,020,372	1,020,372		16.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0		21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0		22.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	5,586,467		30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	1,866,659		34.00
43.00	04300	NURSERY	0	455,549		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-17,412	2,352,971		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,326,304		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	207,515	2,701,833		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	-638,629	2,883,082		55.00
60.00	06000	LABORATORY	0	3,428,002		60.00
64.00	06400	INTRAVENOUS THERAPY	-73,948	1,046,278		64.00
65.00	06500	RESPIRATORY THERAPY	-13,160	1,169,492		65.00
66.00	06600	PHYSICAL THERAPY	-10,699	1,619,171		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	227,415		67.00
68.00	06800	SPEECH PATHOLOGY	0	64,924		68.00
69.00	06900	ELECTROCARDIOLOGY	0	331,344		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	19,251		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	-263,075	5,364,427		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	-153,679	10,229,679		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	16,142,460		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0		78.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
90.01	09001	WOUND CARE INSTITUTE	0	8,269		90.01
90.02	09002	OP NUTRITIONAL COUNSELING	0	59,341		90.02
91.00	09100	EMERGENCY	0	5,245,379		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		OTHER REIMBURSABLE COST CENTERS				
102.00	10200	OPIOID TREATMENT PROGRAM	0	0		102.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	21,839,679	113,295,170		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	116,094		190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	270,035		192.00
194.00	07950	COMMUNITY RELATIONS & MARKETING	0	0		194.00
194.01	07951	PLAINFIELD RADIOLOGY & PHYSICAL THE	0	245,955		194.01
194.02	07952	JV MV ENDOSCOPY	0	0		194.02
194.03	07953	SOUTHWEST CENTER FOR WOMENS HEALTH	0	0		194.03
194.04	07954	OTHER NRCC	5,043,923	23,553,353		194.04
200.00		TOTAL (SUM OF LINES 118 through 199)	26,883,602	137,480,607		200.00

RECLASSIFICATIONS | Provider CCN: 15-0057 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-6 | Date/Time Prepared: 5/31/2024 10:46 am

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - MEDICAL SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	5,627,502		1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	10,383,358		2.00
3.00	INTRAVENOUS THERAPY	64.00	0	0		3.00
4.00	OTHER ADMIN & GENERAL	5.03	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	16,010,860		
	B - DRUGS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	16,142,460		1.00
2.00	DRUGS CHARGED TO PATIENTS	73.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
	0		0	16,142,460		
	C - EQUIPMENT LEASE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	772,247		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	148,997		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
	0		0	921,244		
	D - DEPRECIATION					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	5,358,902		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	2,372,621		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

RECLASSIFICATIONS | Provider CCN: 15-0057 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-6 | Date/Time Prepared: 5/31/2024 10:46 am

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
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
	0		0	7,731,523		
	E - EMPLOYEE BENEFITS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	7,475		1.00
2.00	OTHER ADMIN & GENERAL	5.03	0	729		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
	0		0	8,204		
	F - CAFETERIA					
1.00	CAFETERIA	11.00	322,884	125,803		1.00
	0		322,884	125,803		
	G - NURSERY					
1.00	NURSERY	43.00	449,981	5,568		1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	1,307,077	16,172		2.00
	0		1,757,058	21,740		
	H - CAPITALIZED INTEREST					
1.00	INTEREST EXPENSE	113.00	0	194,543		1.00
	0		0	194,543		
	I - WORKING WELL					
1.00	PHYSICIANS PRIVATE OFFICES	192.00	209,103	55,919		1.00
	TOTALS		209,103	55,919		
	J - J-INSURANCE RECLASS					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	158		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	7,426		2.00
	TOTALS		0	7,584		
500.00	Grand Total: Increases		2,289,045	41,219,880		500.00

RECLASSIFICATIONS | Provider CCN: 15-0057 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-6 | Date/Time Prepared: 5/31/2024 10:46 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - MEDICAL SUPPLIES						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	11,707	0		1.00
2.00	ADMITTING	5.01	0	1,178	0		2.00
3.00	OTHER ADMIN & GENERAL	5.03	0	3,495,285	0		3.00
4.00	OPERATION OF PLANT	7.00	0	2,535	0		4.00
5.00	HOUSEKEEPING	9.00	0	2,009	0		5.00
6.00	DIETARY	10.00	0	10,602	0		6.00
7.00	CAFETERIA	11.00	0	21,828	0		7.00
8.00	CENTRAL SERVICES & SUPPLY	14.00	0	109,066	0		8.00
9.00	PHARMACY	15.00	0	24,889	0		9.00
10.00	ADULTS & PEDIATRICS	30.00	0	334,537	0		10.00
11.00	SURGICAL INTENSIVE CARE UNIT	34.00	0	117,601	0		11.00
12.00	OPERATING ROOM	50.00	0	10,015,689	0		12.00
13.00	DELIVERY ROOM & LABOR ROOM	52.00	0	102	0		13.00
14.00	RADIOLOGY-DIAGNOSTIC	54.00	0	232,602	0		14.00
15.00	RADIOLOGY-THERAPEUTIC	55.00	0	243	0		15.00
16.00	LABORATORY	60.00	0	215,779	0		16.00
17.00	INTRAVENOUS THERAPY	64.00	0	728,236	0		17.00
18.00	RESPIRATORY THERAPY	65.00	0	209,306	0		18.00
19.00	PHYSICAL THERAPY	66.00	0	11,572	0		19.00
20.00	OCCUPATIONAL THERAPY	67.00	0	9,088	0		20.00
21.00	ELECTROCARDIOLOGY	69.00	0	103,577	0		21.00
22.00	ELECTROENCEPHALOGRAPHY	70.00	0	14,301	0		22.00
23.00	WOUND CARE INSTITUTE	90.01	0	1,169	0		23.00
24.00	EMERGENCY	91.00	0	337,959	0		24.00
	0		0	16,010,860			
	B - DRUGS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	18,394	0		1.00
2.00	ADMITTING	5.01	0	23	0		2.00
3.00	OTHER ADMIN & GENERAL	5.03	0	823	0		3.00
4.00	HOUSEKEEPING	9.00	0	555	0		4.00
5.00	PHARMACY	15.00	0	2,069,186	0		5.00
6.00	ADULTS & PEDIATRICS	30.00	0	16,942	0		6.00
7.00	SURGICAL INTENSIVE CARE UNIT	34.00	0	200	0		7.00
8.00	OPERATING ROOM	50.00	0	26,240	0		8.00
9.00	RADIOLOGY-DIAGNOSTIC	54.00	0	36,825	0		9.00
10.00	RADIOLOGY-THERAPEUTIC	55.00	0	56,991	0		10.00
11.00	LABORATORY	60.00	0	3	0		11.00
12.00	INTRAVENOUS THERAPY	64.00	0	13,859,335	0		12.00
13.00	RESPIRATORY THERAPY	65.00	0	131	0		13.00
14.00	ELECTROCARDIOLOGY	69.00	0	31,261	0		14.00
15.00	EMERGENCY	91.00	0	24,826	0		15.00
16.00	CENTRAL SERVICES & SUPPLY	14.00	0	725	0		16.00
	0		0	16,142,460			
	C - EQUIPMENT LEASE						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	95,139	9		1.00
2.00	OTHER ADMIN & GENERAL	5.03	0	12,671	9		2.00
3.00	OPERATION OF PLANT	7.00	0	43,147	0		3.00
4.00	CENTRAL SERVICES & SUPPLY	14.00	0	198	0		4.00
5.00	PHARMACY	15.00	0	41,630	0		5.00
6.00	ADULTS & PEDIATRICS	30.00	0	417	0		6.00
7.00	OPERATING ROOM	50.00	0	105,460	0		7.00
8.00	INTRAVENOUS THERAPY	64.00	0	197,286	0		8.00
9.00	RESPIRATORY THERAPY	65.00	0	371	0		9.00
10.00	PHYSICAL THERAPY	66.00	0	2,000	0		10.00
11.00	EMERGENCY	91.00	0	6,422	0		11.00
12.00	PLAINFIELD RADIOLOGY & PHYSICAL THE	194.01	0	190,798	0		12.00
13.00	OTHER NRCC	194.04	0	225,705	0		13.00
	0		0	921,244			
	D - DEPRECIATION						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	24,323	9		1.00
2.00	OTHER ADMIN & GENERAL	5.03	0	373,303	9		2.00
3.00	OPERATION OF PLANT	7.00	0	150,280	0		3.00
4.00	LAUNDRY & LINEN SERVICE	8.00	0	1,069	0		4.00
5.00	HOUSEKEEPING	9.00	0	31,150	0		5.00
6.00	DIETARY	10.00	0	10,079	0		6.00
7.00	CAFETERIA	11.00	0	2,011	0		7.00
8.00	NURSING ADMINISTRATION	13.00	0	2,579	0		8.00
9.00	CENTRAL SERVICES & SUPPLY	14.00	0	26,912	0		9.00
10.00	PHARMACY	15.00	0	36,963	0		10.00
11.00	ADULTS & PEDIATRICS	30.00	0	166,199	0		11.00
12.00	SURGICAL INTENSIVE CARE UNIT	34.00	0	56,127	0		12.00
13.00	OPERATING ROOM	50.00	0	812,756	0		13.00

RECLASSIFICATIONS | Provider CCN: 15-0057 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-6 | Date/Time Prepared: 5/31/2024 10:46 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
14.00	RADIOLOGY-DIAGNOSTIC	54.00	0	519,552	0		14.00
15.00	RADIOLOGY-THERAPEUTIC	55.00	0	690,880	0		15.00
16.00	LABORATORY	60.00	0	44,372	0		16.00
17.00	INTRAVENOUS THERAPY	64.00	0	122,671	0		17.00
18.00	RESPIRATORY THERAPY	65.00	0	51,073	0		18.00
19.00	PHYSICAL THERAPY	66.00	0	58,112	0		19.00
20.00	ELECTROCARDIOLOGY	69.00	0	1,151	0		20.00
21.00	ELECTROENCEPHALOGRAPHY	70.00	0	29,176	0		21.00
22.00	OP NUTRITIONAL COUNSELING	90.02	0	347	0		22.00
23.00	EMERGENCY	91.00	0	110,329	0		23.00
24.00	PLAINFIELD RADIOLOGY & PHYSICAL THE	194.01	0	7,736	0		24.00
25.00	OTHER NRCC	194.04	0	4,402,373	0		25.00
	0		0	7,731,523			
	E - EMPLOYEE BENEFITS						
1.00	OPERATION OF PLANT	7.00	0	1	0		1.00
2.00	HOUSEKEEPING	9.00	0	2	0		2.00
3.00	DIETARY	10.00	0	1	0		3.00
4.00	NURSING ADMINISTRATION	13.00	0	1	0		4.00
5.00	PHARMACY	15.00	0	1	0		5.00
6.00	ADULTS & PEDIATRICS	30.00	0	4,843	0		6.00
7.00	SURGICAL INTENSIVE CARE UNIT	34.00	0	2	0		7.00
8.00	OPERATING ROOM	50.00	0	3	0		8.00
9.00	RADIOLOGY-DIAGNOSTIC	54.00	0	2	0		9.00
10.00	RESPIRATORY THERAPY	65.00	0	3,342	0		10.00
11.00	PHYSICAL THERAPY	66.00	0	2	0		11.00
12.00	EMERGENCY	91.00	0	4	0		12.00
	0		0	8,204			
	F - CAFETERIA						
1.00	DIETARY	10.00	322,884	125,803	0		1.00
	0		322,884	125,803			
	G - NURSERY						
1.00	ADULTS & PEDIATRICS	30.00	1,757,058	21,740	0		1.00
2.00		0.00	0	0	0		2.00
	0		1,757,058	21,740			
	H - CAPITALIZED INTEREST						
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	194,543	11		1.00
	0		0	194,543			
	I - WORKING WELL						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	209,103	55,919	0		1.00
	TOTALS		209,103	55,919			
	J - J-INSURANCE RECLASS						
1.00	OTHER ADMIN & GENERAL	5.03	0	7,426	9		1.00
2.00	EMERGENCY	91.00	0	158	9		2.00
	TOTALS		0	7,584			
500.00	Grand Total: Decreases		2,289,045	41,219,880			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0057 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-7 Part I | Date/Time Prepared: 5/31/2024 10:46 am

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	0	0	0	0	0	1.00
2.00	Land Improvements	2,622,652	0	0	0	0	2.00
3.00	Buildings and Fixtures	63,285,635	749,100	0	749,100	0	3.00
4.00	Building Improvements	2,174,884	0	0	0	0	4.00
5.00	Fixed Equipment	46,334,521	0	0	0	0	5.00
6.00	Movable Equipment	29,640,108	377,020	0	377,020	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	144,057,800	1,126,120	0	1,126,120	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	144,057,800	1,126,120	0	1,126,120	0	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	0	0	1.00
2.00	Land Improvements	2,622,652	0	2.00
3.00	Buildings and Fixtures	64,034,735	0	3.00
4.00	Building Improvements	2,174,884	0	4.00
5.00	Fixed Equipment	46,334,521	0	5.00
6.00	Movable Equipment	30,017,128	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	145,183,920	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	145,183,920	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0057 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-7 Part II | Date/Time Prepared: 5/31/2024 10:46 am

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

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

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0057 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-7 Part III | Date/Time Prepared: 5/31/2024 10:46 am

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	115,166,792	0	115,166,792	0.803854	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	30,017,128	1,915,542	28,101,586	0.196146	0	2.00
3.00	Total (sum of lines 1-2)	145,183,920	1,915,542	143,268,378	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	6,266,867	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	3,405,235	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	9,672,102	0	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	1,213,445	0	0	0	7,480,312	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	-194,543	0	0	0	3,210,692	2.00
3.00	Total (sum of lines 1-2)	1,018,902	0	0	0	10,691,004	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0057 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-8 | Date/Time Prepared: 5/31/2024 10:46 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)	B	0	INTRAVENOUS THERAPY	64.00	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)	A	0	OPERATION OF PLANT	7.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-3,247,175			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	37,937,502			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-321,989	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	-10,136	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	MISC INCOME	B	-94,385	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0057 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-8 | Date/Time Prepared: 5/31/2024 10:46 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.01	MISC INCOME	B	-6,381	OTHER ADMIN & GENERAL	5.03	0	33.01
33.02	MISC INCOME	B	-135,625	OPERATION OF PLANT	7.00	0	33.02
33.03	MISC INCOME	B	-27,245	LAUNDRY & LINEN SERVICE	8.00	0	33.03
33.04	MISC INCOME	B	-12,250	HOUSEKEEPING	9.00	0	33.04
33.05	MISC INCOME	B	-11	DIETARY	10.00	0	33.05
33.06	MISC INCOME	B	19,776	CAFETERIA	11.00	0	33.06
33.07	MISC INCOME	B	0	NURSING ADMINISTRATION	13.00	0	33.07
33.08	MISC INCOME	B	-19,958	CENTRAL SERVICES & SUPPLY	14.00	0	33.08
33.09	MISC INCOME	B	-71,230	PHARMACY	15.00	0	33.09
33.10	MISC INCOME	B	-17,412	OPERATING ROOM	50.00	0	33.10
33.11	MISC INCOME	B	-51,692	RADIOLOGY-DIAGNOSTIC	54.00	0	33.11
33.12	MISC INCOME	B	-73,948	INTRAVENOUS THERAPY	64.00	0	33.12
33.13	MISC INCOME	B	-2,031	RESPIRATORY THERAPY	65.00	0	33.13
33.14	MISC INCOME	B	-10,699	PHYSICAL THERAPY	66.00	0	33.14
33.15	MISC INCOME	B	-638,629	RADIOLOGY-THERAPEUTIC	55.00	0	33.15
33.16	MISC INCOME	B	-263,075	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	33.16
33.17	MISC INCOME	B	-153,679	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	33.17
33.18	VENDING MACHINES	B	0	DIETARY	10.00	0	33.18
33.19	LOBBYING FEES	A	-3,130	OTHER ADMIN & GENERAL	5.03	0	33.19
33.20	ON CALL COVERAGE	A	0	OTHER ADMIN & GENERAL	5.03	0	33.20
33.21	ON CALL COVERAGE	A	0	ADULTS & PEDIATRICS	30.00	0	33.21
33.22	NON ALLOWABLE INTEREST	A	0	CAP REL COSTS-BLDG & FIXT	1.00	11	33.22
33.23	HAF OFFSET	A	-5,906,953	OTHER ADMIN & GENERAL	5.03	0	33.23
33.24	PENSION ADJ PER REGS 2142.5	A	0	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.24
33.25	ADVERTISING	A	0	OTHER ADMIN & GENERAL	5.03	0	33.25
33.26	DUES AND SUBSCRIPTIONS	A	0	EMERGENCY	91.00	0	33.26
33.27	DUES AND SUBSCRIPTIONS	A	0	OTHER ADMIN & GENERAL	5.03	0	33.27
33.28	MISC EXPENSE	A	0	OPERATION OF PLANT	7.00	0	33.28
33.29	MISC EXPENSE	A	0	HOUSEKEEPING	9.00	0	33.29
33.30	MISC EXPENSE	A	0	NURSING ADMINISTRATION	13.00	0	33.30
33.31	MISC EXPENSE	A	0	RADIOLOGY-DIAGNOSTIC	54.00	0	33.31
33.32	MISC EXPENSE	A	0	PHYSICAL THERAPY	66.00	0	33.32
33.33	DUES AND SUBSCRIPTIONS	A	0	NURSING ADMINISTRATION	13.00	0	33.33
34.00	ADVERTISING	A	-2,730	OTHER ADMIN & GENERAL	5.03	0	34.00
34.01	ADVERTISING	A	-3,313	OPERATION OF PLANT	7.00	0	34.01
34.02	OTHER HOSP LOCATION	A	0		0.00	0	34.02
34.03	OTHER HOSP LOCATION	A	0		0.00	0	34.03
34.04	OTHER HOSP LOCATION	A	0		0.00	0	34.04
34.05	OTHER HOSP LOCATION	A	0		0.00	0	34.05
35.00	NON-HOSP LOCATION	B	0	OTHER ADMIN & GENERAL	5.03	0	35.00
35.01	NON-HOSP LOCATION	A	0	OTHER ADMIN & GENERAL	5.03	0	35.01
35.02	NON-HOSP LOCATION	A	0	CENTRAL SERVICES & SUPPLY	14.00	0	35.02
35.03	NON-HOSP LOCATION	A	0	LABORATORY	60.00	0	35.03
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		26,883,602				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: 15-0057 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-8-1 | Date/Time Prepared: 5/31/2024 10:46 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	0.00		SHARED SERVICE ALLOCATION	0	0	1.00
2.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	SHARED SERVICE ALLOCATION	6,950,571	0	2.00
3.00	5.03	OTHER ADMIN & GENERAL	SHARED SERVICE ALLOCATION	3,724,169	0	3.00
4.00	7.00	OPERATION OF PLANT	SHARED SERVICE ALLOCAITON	1,180,654	0	4.00
4.01	13.00	NURSING ADMINISTRATION	SHARED SERVICE ALLOCATION	61,519	0	4.01
4.02	16.00	MEDICAL RECORDS & LIBRARY	SHARED SERVICE ALLOCATION	14,035	0	4.02
4.03	54.00	RADIOLOGY-DIAGNOSTIC	SHARED SERVICE ALLOCATION	259,207	0	4.03
4.04	0.00			0	0	4.04
4.05	194.04	OTHER NRCC	SHARED SERVICE ALLOCATION	5,043,923	0	4.05
4.06	0.00			0	0	4.06
4.07	1.00	CAP REL COSTS-BLDG & FIXT	FRANCISCAN HOME OFFICE	135,560	0	4.07
4.08	1.00	CAP REL COSTS-BLDG & FIXT	FRANCISCAN HOME OFFICE	1,213,445	0	4.08
4.09	2.00	CAP REL COSTS-MVBLE EQUIP	FRANCISCAN HOME OFFICE	876,191	0	4.09
4.10	5.03	OTHER ADMIN & GENERAL	FRANCISCAN HOME OFFICE	17,293,234	0	4.10
4.11	15.00	PHARMACY	FRANCISCAN HOME OFFICE	178,657	0	4.11
4.12	16.00	MEDICAL RECORDS & LIBRARY	FRANCISCAN HOME OFFICE	1,006,337	0	4.12
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			37,937,502	0	5.00

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

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

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

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

6.00	B	HOME OFFICE	100.00	FRANC. ALLIANCE	100.00	6.00
7.00	B	APHL	100.00	APHL	100.00	7.00
8.00	G	FH CENTRAL INDY	100.00	FRANC. HEALTH	100.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 15-0057	Period: From 01/01/2023 To 12/31/2023	Worksheet A-8-1 Date/Time Prepared: 5/31/2024 10:46 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	0	9		1.00
2.00	6,950,571	0		2.00
3.00	3,724,169	0		3.00
4.00	1,180,654	0		4.00
4.01	61,519	0		4.01
4.02	14,035	0		4.02
4.03	259,207	0		4.03
4.04	0	0		4.04
4.05	5,043,923	0		4.05
4.06	0	0		4.06
4.07	135,560	9		4.07
4.08	1,213,445	11		4.08
4.09	876,191	9		4.09
4.10	17,293,234	0		4.10
4.11	178,657	0		4.11
4.12	1,006,337	0		4.12
5.00	37,937,502			5.00

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

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

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

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

6.00	HEALTH SYSTEM		6.00
7.00	SHARED LAB		7.00
8.00	HOSPITAL		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: 15-0057 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-8-2 | Date/Time Prepared: 5/31/2024 10:46 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	1,424	1,424	0	0	10	1.00
2.00	5.03	OTHER ADMIN & GENERAL	3,234,622	3,234,622	0	0	0	2.00
3.00	65.00	RESPIRATORY THERAPY	11,129	11,129	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			3,247,175	3,247,175	0		10	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	4.00	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	1.00
2.00	5.03	OTHER ADMIN & GENERAL	0	0	0	0	0	2.00
3.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	1,424		1.00
2.00	5.03	OTHER ADMIN & GENERAL	0	0	0	3,234,622		2.00
3.00	65.00	RESPIRATORY THERAPY	0	0	0	11,129		3.00
4.00	0.00		0	0	0	0		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	3,247,175		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0057 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I Date/Time Prepared: 5/31/2024 10:46 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	ADMITTING	
			0	1.00	2.00	4.00	5.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	7,480,312	7,480,312				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	3,210,692		3,210,692			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	6,949,279	0	0	6,949,279		4.00
5.01	00570	ADMITTING	205	72,903	31,291	0	104,399	5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	0	0	0	0	5.02
5.03	00590	OTHER ADMIN & GENERAL	22,729,620	274,969	118,022	200,360	0	5.03
7.00	00700	OPERATION OF PLANT	4,947,910	937,555	402,417	331,650	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	285,361	26,925	11,557	14,861	0	8.00
9.00	00900	HOUSEKEEPING	1,912,612	79,262	34,021	335,664	0	9.00
10.00	01000	DIETARY	234,449	110,803	47,559	35,691	0	10.00
11.00	01100	CAFETERIA	335,245	95,161	40,845	98,815	0	11.00
13.00	01300	NURSING ADMINISTRATION	677,260	3,282	1,409	166,880	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	261,203	58,338	25,040	40,999	0	14.00
15.00	01500	PHARMACY	1,122,353	102,982	44,202	264,221	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,020,372	0	0	0	0	16.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,586,467	1,374,254	589,856	835,826	14,834	30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	1,866,659	225,760	96,900	447,779	4,519	34.00
43.00	04300	NURSERY	455,549	0	0	122,675	1,683	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,352,971	667,587	286,541	578,697	18,496	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,326,304	0	0	356,992	5,002	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,701,833	278,482	119,530	598,481	4,603	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	2,883,082	210,887	90,517	141,966	257	55.00
60.00	06000	LABORATORY	3,428,002	120,086	51,543	0	7,974	60.00
64.00	06400	INTRAVENOUS THERAPY	1,046,278	0	0	258,025	701	64.00
65.00	06500	RESPIRATORY THERAPY	1,169,492	52,850	22,684	320,137	3,081	65.00
66.00	06600	PHYSICAL THERAPY	1,619,171	216,426	92,894	439,655	2,025	66.00
67.00	06700	OCCUPATIONAL THERAPY	227,415	126,137	54,141	61,427	221	67.00
68.00	06800	SPEECH PATHOLOGY	64,924	0	0	17,350	252	68.00
69.00	06900	ELECTROCARDIOLOGY	331,344	94,622	40,614	88,424	1,384	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	19,251	102,674	44,070	3,695	113	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	5,364,427	0	0	0	10,545	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	10,229,679	0	0	0	11,403	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	16,142,460	0	0	0	7,508	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CARE INSTITUTE	8,269	0	0	2,254	0	90.01
90.02	09002	OP NUTRITIONAL COUNSELING	59,341	0	0	16,159	0	90.02
91.00	09100	EMERGENCY	5,245,379	392,413	168,431	1,032,810	9,798	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	113,295,170	5,624,358	2,414,084	6,811,493	104,399	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	116,094	34,079	14,628	11,455	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	270,035	0	0	58,034	0	192.00
194.00	07950	COMMUNITY RELATIONS & MARKETING	0	0	0	0	0	194.00
194.01	07951	PLAINFIELD RADIOLOGY & PHYSICAL THE	245,955	0	0	64,185	0	194.01
194.02	07952	JV MV ENDOSCOPY	0	0	0	0	0	194.02
194.03	07953	SOUTHWEST CENTER FOR WOMENS HEALTH	0	0	0	0	0	194.03
194.04	07954	OTHER NRCC	23,553,353	1,821,875	781,980	4,112	0	194.04
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)	137,480,607	7,480,312	3,210,692	6,949,279	104,399	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0057 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I | Date/Time Prepared: 5/31/2024 10:46 am

		Cost Center Description	CASHIERING/ACCOUNTS RECEIVABLE	Subtotal	OTHER ADMIN & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
			5.02	5A.02	5.03	7.00	8.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE	0					5.02
5.03	00590	OTHER ADMIN & GENERAL	0	23,322,971	23,322,971			5.03
7.00	00700	OPERATION OF PLANT	0	6,619,532	1,352,403	7,971,935		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	338,704	69,199	34,649	442,552	8.00
9.00	00900	HOUSEKEEPING	0	2,361,559	482,478	101,999	0	9.00
10.00	01000	DIETARY	0	428,502	87,545	142,588	0	10.00
11.00	01100	CAFETERIA	0	570,066	116,467	122,458	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	848,831	173,420	4,224	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	385,580	78,776	75,072	0	14.00
15.00	01500	PHARMACY	0	1,533,758	313,354	132,523	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,020,372	208,467	0	0	16.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	8,401,237	1,716,415	1,768,469	120,693	30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	2,641,617	539,696	290,521	0	34.00
43.00	04300	NURSERY	0	579,907	118,478	0	27,320	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	3,904,292	797,666	859,089	60,172	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,688,298	344,928	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,702,929	756,527	358,366	51,874	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	3,326,709	679,663	271,382	298	55.00
60.00	06000	LABORATORY	0	3,607,605	737,052	154,533	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	1,305,004	266,619	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	1,568,244	320,400	68,010	0	65.00
66.00	06600	PHYSICAL THERAPY	0	2,370,171	484,238	278,509	10,838	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	469,341	95,889	162,321	3,090	67.00
68.00	06800	SPEECH PATHOLOGY	0	82,526	16,860	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	556,388	113,673	121,765	10,193	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	169,803	34,692	132,127	73	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	5,374,972	1,098,134	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	10,241,082	2,092,304	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	16,149,968	3,299,519	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CARE INSTITUTE	0	10,523	2,150	0	0	90.01
90.02	09002	OP NUTRITIONAL COUNSELING	0	75,500	15,425	0	0	90.02
91.00	09100	EMERGENCY	0	6,848,831	1,399,250	504,980	94,865	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0				92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	110,504,822	17,811,687	5,583,585	379,416	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	176,256	36,010	43,855	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	328,069	67,026	0	2,349	192.00
194.00	07950	COMMUNITY RELATIONS & MARKETING	0	0	0	0	0	194.00
194.01	07951	PLAINFIELD RADIOLOGY & PHYSICAL THE	0	310,140	63,363	0	0	194.01
194.02	07952	JV MV ENDOSCOPY	0	0	0	0	0	194.02
194.03	07953	SOUTHWEST CENTER FOR WOMENS HEALTH	0	0	0	0	0	194.03
194.04	07954	OTHER NRCC	0	26,161,320	5,344,885	2,344,495	60,787	194.04
200.00		Cross Foot Adjustments		0				200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	137,480,607	23,322,971	7,971,935	442,552	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0057 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I | Date/Time Prepared: 5/31/2024 10:46 am

		Cost Center Description	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			9.00	10.00	11.00	13.00	14.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.02
5.03	00590	OTHER ADMIN & GENERAL						5.03
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	2,946,036					9.00
10.00	01000	DIETARY	53,612	712,247				10.00
11.00	01100	CAFETERIA	46,044	0	855,035			11.00
13.00	01300	NURSING ADMINISTRATION	1,588	0	18,717	1,046,780		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	28,227	0	8,030	0	575,685	14.00
15.00	01500	PHARMACY	49,828	0	34,487	0	398	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	664,937	535,801	241,954	371,600	1,452	30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	109,235	118,935	0	0	291	34.00
43.00	04300	NURSERY	0	57,511	73,633	145,238	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	323,014	0	99,052	116,456	5,327	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	2	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	134,744	0	98,147	0	858	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	102,038	0	0	0	118	55.00
60.00	06000	LABORATORY	58,104	0	0	0	4	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	20,862	50,773	342	64.00
65.00	06500	RESPIRATORY THERAPY	25,572	0	36,569	0	64	65.00
66.00	06600	PHYSICAL THERAPY	104,718	0	46,415	0	345	66.00
67.00	06700	OCCUPATIONAL THERAPY	61,032	0	5,433	0	53	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	1,583	0	1	68.00
69.00	06900	ELECTROCARDIOLOGY	45,783	0	9,874	0	53	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	49,679	0	0	0	9	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	199,401	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	365,784	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CARE INSTITUTE	0	0	0	0	0	90.01
90.02	09002	OP NUTRITIONAL COUNSELING	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	189,870	0	150,541	362,713	836	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,048,025	712,247	845,297	1,046,780	575,338	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	16,489	0	2,884	0	87	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	COMMUNITY RELATIONS & MARKETING	0	0	0	0	0	194.00
194.01	07951	PLAINFIELD RADIOLOGY & PHYSICAL THE	0	0	6,197	0	57	194.01
194.02	07952	JV MV ENDOSCOPY	0	0	0	0	0	194.02
194.03	07953	SOUTHWEST CENTER FOR WOMENS HEALTH	0	0	0	0	0	194.03
194.04	07954	OTHER NRCC	881,522	0	657	0	203	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	2,946,036	712,247	855,035	1,046,780	575,685	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0057 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I | Date/Time Prepared: 5/31/2024 10:46 am

		Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES APPRV	INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS APPRV	Subtotal	
			15.00	16.00	21.00	22.00	24.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.02
5.03	00590	OTHER ADMIN & GENERAL						5.03
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	2,064,348					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,228,839				16.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0		0		22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	48,936	0	0	13,871,494	30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	10,966	0	0	3,711,261	34.00
43.00	04300	NURSERY	0	4,084	0	0	1,006,171	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	119,301	0	0	6,284,369	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	12,202	0	0	2,045,430	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	146,204	0	0	5,249,649	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	65,753	0	0	4,445,961	55.00
60.00	06000	LABORATORY	0	92,119	0	0	4,649,417	60.00
64.00	06400	INTRAVENOUS THERAPY	0	42,242	0	0	1,685,842	64.00
65.00	06500	RESPIRATORY THERAPY	0	16,229	0	0	2,035,088	65.00
66.00	06600	PHYSICAL THERAPY	0	30,345	0	0	3,325,579	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	4,071	0	0	801,230	67.00
68.00	06800	SPEECH PATHOLOGY	0	1,153	0	0	102,123	68.00
69.00	06900	ELECTROCARDIOLOGY	0	36,185	0	0	893,914	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	4,818	0	0	391,201	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	65,344	0	0	6,737,851	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	80,405	0	0	12,779,575	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,064,348	220,287	0	0	21,734,122	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CARE INSTITUTE	0	10	0	0	12,683	90.01
90.02	09002	OP NUTRITIONAL COUNSELING	0	138	0	0	91,063	90.02
91.00	09100	EMERGENCY	0	228,047	0	0	9,779,933	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,064,348	1,228,839	0	0	101,633,956	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	275,581	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	397,444	192.00
194.00	07950	COMMUNITY RELATIONS & MARKETING	0	0	0	0	0	194.00
194.01	07951	PLAINFIELD RADIOLOGY & PHYSICAL THE	0	0	0	0	379,757	194.01
194.02	07952	JV MV ENDOSCOPY	0	0	0	0	0	194.02
194.03	07953	SOUTHWEST CENTER FOR WOMENS HEALTH	0	0	0	0	0	194.03
194.04	07954	OTHER NRCC	0	0	0	0	34,793,869	194.04
200.00		Cross Foot Adjustments			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)	2,064,348	1,228,839	0	0	137,480,607	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0057 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I | Date/Time Prepared: 5/31/2024 10:46 am

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			25.00	26.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.01	00570	ADMITTING				5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE				5.02
5.03	00590	OTHER ADMIN & GENERAL				5.03
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
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV				21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV				22.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	13,871,494		30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	3,711,261		34.00
43.00	04300	NURSERY	0	1,006,171		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	6,284,369		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	2,045,430		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	5,249,649		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	4,445,961		55.00
60.00	06000	LABORATORY	0	4,649,417		60.00
64.00	06400	INTRAVENOUS THERAPY	0	1,685,842		64.00
65.00	06500	RESPIRATORY THERAPY	0	2,035,088		65.00
66.00	06600	PHYSICAL THERAPY	0	3,325,579		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	801,230		67.00
68.00	06800	SPEECH PATHOLOGY	0	102,123		68.00
69.00	06900	ELECTROCARDIOLOGY	0	893,914		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	391,201		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	6,737,851		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	12,779,575		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	21,734,122		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0		78.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
90.01	09001	WOUND CARE INSTITUTE	0	12,683		90.01
90.02	09002	OP NUTRITIONAL COUNSELING	0	91,063		90.02
91.00	09100	EMERGENCY	0	9,779,933		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0			92.00
		OTHER REIMBURSABLE COST CENTERS				
102.00	10200	OPIOID TREATMENT PROGRAM	0	0		102.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	101,633,956		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	275,581		190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	397,444		192.00
194.00	07950	COMMUNITY RELATIONS & MARKETING	0	0		194.00
194.01	07951	PLAINFIELD RADIOLOGY & PHYSICAL THE	0	379,757		194.01
194.02	07952	JV MV ENDOSCOPY	0	0		194.02
194.03	07953	SOUTHWEST CENTER FOR WOMENS HEALTH	0	0		194.03
194.04	07954	OTHER NRCC	0	34,793,869		194.04
200.00		Cross Foot Adjustments	0	0		200.00
201.00		Negative Cost Centers	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	0	137,480,607		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0057 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II Date/Time Prepared: 5/31/2024 10:46 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.01	00570	ADMITTING	0	72,903	31,291	104,194	0	5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	0	0	0	0	5.02
5.03	00590	OTHER ADMIN & GENERAL	0	274,969	118,022	392,991	0	5.03
7.00	00700	OPERATION OF PLANT	0	937,555	402,417	1,339,972	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	26,925	11,557	38,482	0	8.00
9.00	00900	HOUSEKEEPING	0	79,262	34,021	113,283	0	9.00
10.00	01000	DIETARY	0	110,803	47,559	158,362	0	10.00
11.00	01100	CAFETERIA	0	95,161	40,845	136,006	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	3,282	1,409	4,691	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	58,338	25,040	83,378	0	14.00
15.00	01500	PHARMACY	0	102,982	44,202	147,184	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	1,374,254	589,856	1,964,110	0	30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	225,760	96,900	322,660	0	34.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	667,587	286,541	954,128	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	278,482	119,530	398,012	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	210,887	90,517	301,404	0	55.00
60.00	06000	LABORATORY	0	120,086	51,543	171,629	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	52,850	22,684	75,534	0	65.00
66.00	06600	PHYSICAL THERAPY	0	216,426	92,894	309,320	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	126,137	54,141	180,278	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	94,622	40,614	135,236	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	102,674	44,070	146,744	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
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CARE INSTITUTE	0	0	0	0	0	90.01
90.02	09002	OP NUTRITIONAL COUNSELING	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	0	392,413	168,431	560,844	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	5,624,358	2,414,084	8,038,442	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	34,079	14,628	48,707	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	COMMUNITY RELATIONS & MARKETING	0	0	0	0	0	194.00
194.01	07951	PLAINFIELD RADIOLOGY & PHYSICAL THE	0	0	0	0	0	194.01
194.02	07952	JV MV ENDOSCOPY	0	0	0	0	0	194.02
194.03	07953	SOUTHWEST CENTER FOR WOMENS HEALTH	0	0	0	0	0	194.03
194.04	07954	OTHER NRCC	0	1,821,875	781,980	2,603,855	0	194.04
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	7,480,312	3,210,692	10,691,004	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0057 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II Date/Time Prepared: 5/31/2024 10:46 am

		Cost Center Description	ADMITTING	CASHIERING/ACCOUNTS RECEIVABLE	OTHER ADMIN & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
			5.01	5.02	5.03	7.00	8.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING	104,194					5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	0				5.02
5.03	00590	OTHER ADMIN & GENERAL	0	0	392,991			5.03
7.00	00700	OPERATION OF PLANT	0	0	22,791	1,362,763		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	1,166	5,923	45,571	8.00
9.00	00900	HOUSEKEEPING	0	0	8,131	17,436	0	9.00
10.00	01000	DIETARY	0	0	1,475	24,375	0	10.00
11.00	01100	CAFETERIA	0	0	1,963	20,934	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	2,923	722	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	1,328	12,833	0	14.00
15.00	01500	PHARMACY	0	0	5,281	22,654	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	3,513	0	0	16.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	14,815	0	28,925	302,311	12,427	30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	4,514	0	9,095	49,663	0	34.00
43.00	04300	NURSERY	1,681	0	1,997	0	2,813	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	18,398	0	13,442	146,857	6,196	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,995	0	5,813	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,598	0	12,749	61,261	5,342	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	257	0	11,454	46,391	31	55.00
60.00	06000	LABORATORY	7,964	0	12,421	26,417	0	60.00
64.00	06400	INTRAVENOUS THERAPY	700	0	4,493	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	3,077	0	5,399	11,626	0	65.00
66.00	06600	PHYSICAL THERAPY	2,023	0	8,160	47,610	1,116	66.00
67.00	06700	OCCUPATIONAL THERAPY	220	0	1,616	27,748	318	67.00
68.00	06800	SPEECH PATHOLOGY	252	0	284	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,382	0	1,916	20,815	1,050	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	113	0	585	22,586	8	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	10,532	0	18,506	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	11,389	0	35,260	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,498	0	55,604	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CARE INSTITUTE	0	0	36	0	0	90.01
90.02	09002	OP NUTRITIONAL COUNSELING	0	0	260	0	0	90.02
91.00	09100	EMERGENCY	9,786	0	23,581	86,324	9,769	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	104,194	0	300,167	954,486	39,070	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	607	7,497	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	1,130	0	242	192.00
194.00	07950	COMMUNITY RELATIONS & MARKETING	0	0	0	0	0	194.00
194.01	07951	PLAINFIELD RADIOLOGY & PHYSICAL THE	0	0	1,068	0	0	194.01
194.02	07952	JV MV ENDOSCOPY	0	0	0	0	0	194.02
194.03	07953	SOUTHWEST CENTER FOR WOMENS HEALTH	0	0	0	0	0	194.03
194.04	07954	OTHER NRCC	0	0	90,019	400,780	6,259	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	104,194	0	392,991	1,362,763	45,571	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0057 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II | Date/Time Prepared: 5/31/2024 10:46 am

		Cost Center Description	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			9.00	10.00	11.00	13.00	14.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.02
5.03	00590	OTHER ADMIN & GENERAL						5.03
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	138,850					9.00
10.00	01000	DIETARY	2,527	186,739				10.00
11.00	01100	CAFETERIA	2,170	0	161,073			11.00
13.00	01300	NURSING ADMINISTRATION	75	0	3,526	11,937		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,330	0	1,513	0	100,382	14.00
15.00	01500	PHARMACY	2,348	0	6,497	0	69	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	31,339	140,478	45,579	4,238	253	30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	5,148	31,183	0	0	51	34.00
43.00	04300	NURSERY	0	15,078	13,871	1,656	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	15,224	0	18,660	1,328	929	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,351	0	18,489	0	150	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	4,809	0	0	0	20	55.00
60.00	06000	LABORATORY	2,738	0	0	0	1	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	3,930	579	60	64.00
65.00	06500	RESPIRATORY THERAPY	1,205	0	6,889	0	11	65.00
66.00	06600	PHYSICAL THERAPY	4,935	0	8,744	0	60	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,877	0	1,024	0	9	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	298	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	2,158	0	1,860	0	9	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	2,341	0	0	0	2	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	34,769	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	63,783	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CARE INSTITUTE	0	0	0	0	0	90.01
90.02	09002	OP NUTRITIONAL COUNSELING	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	8,949	0	28,359	4,136	146	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	96,524	186,739	159,239	11,937	100,322	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	777	0	543	0	15	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	COMMUNITY RELATIONS & MARKETING	0	0	0	0	0	194.00
194.01	07951	PLAINFIELD RADIOLOGY & PHYSICAL THE	0	0	1,167	0	10	194.01
194.02	07952	JV MV ENDOSCOPY	0	0	0	0	0	194.02
194.03	07953	SOUTHWEST CENTER FOR WOMENS HEALTH	0	0	0	0	0	194.03
194.04	07954	OTHER NRCC	41,549	0	124	0	35	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	138,850	186,739	161,073	11,937	100,382	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0057 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II Date/Time Prepared: 5/31/2024 10:46 am

		Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES APPRV	INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS APPRV	Subtotal	
			15.00	16.00	21.00	22.00	24.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.02
5.03	00590	OTHER ADMIN & GENERAL						5.03
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	184,033					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	3,513				16.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0		0		22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	152			2,544,627	30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	34			422,348	34.00
43.00	04300	NURSERY	0	13			37,109	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	371			1,175,533	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	38			10,846	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	455			507,407	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	205			364,571	55.00
60.00	06000	LABORATORY	0	287			221,457	60.00
64.00	06400	INTRAVENOUS THERAPY	0	131			9,893	64.00
65.00	06500	RESPIRATORY THERAPY	0	50			103,791	65.00
66.00	06600	PHYSICAL THERAPY	0	94			382,062	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	13			214,103	67.00
68.00	06800	SPEECH PATHOLOGY	0	4			838	68.00
69.00	06900	ELECTROCARDIOLOGY	0	113			164,539	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	15			172,394	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	203			64,010	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	250			110,682	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	184,033	685			247,820	73.00
74.00	07400	RENAL DIALYSIS	0	0			0	74.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0			0	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0			0	90.00
90.01	09001	WOUND CARE INSTITUTE	0	0			36	90.01
90.02	09002	OP NUTRITIONAL COUNSELING	0	0			260	90.02
91.00	09100	EMERGENCY	0	400			732,294	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0			0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	184,033	3,513	0	0	7,486,620	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0			58,146	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0			1,372	192.00
194.00	07950	COMMUNITY RELATIONS & MARKETING	0	0			0	194.00
194.01	07951	PLAINFIELD RADIOLOGY & PHYSICAL THE	0	0			2,245	194.01
194.02	07952	JV MV ENDOSCOPY	0	0			0	194.02
194.03	07953	SOUTHWEST CENTER FOR WOMENS HEALTH	0	0			0	194.03
194.04	07954	OTHER NRCC	0	0			3,142,621	194.04
200.00		Cross Foot Adjustments			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)	184,033	3,513	0	0	10,691,004	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0057 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II | Date/Time Prepared: 5/31/2024 10:46 am

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			25.00	26.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.01	00570	ADMITTING				5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE				5.02
5.03	00590	OTHER ADMIN & GENERAL				5.03
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
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV				21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV				22.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	2,544,627		30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	422,348		34.00
43.00	04300	NURSERY	0	37,109		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	1,175,533		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	10,846		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	507,407		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	364,571		55.00
60.00	06000	LABORATORY	0	221,457		60.00
64.00	06400	INTRAVENOUS THERAPY	0	9,893		64.00
65.00	06500	RESPIRATORY THERAPY	0	103,791		65.00
66.00	06600	PHYSICAL THERAPY	0	382,062		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	214,103		67.00
68.00	06800	SPEECH PATHOLOGY	0	838		68.00
69.00	06900	ELECTROCARDIOLOGY	0	164,539		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	172,394		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	64,010		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	110,682		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	247,820		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0		78.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
90.01	09001	WOUND CARE INSTITUTE	0	36		90.01
90.02	09002	OP NUTRITIONAL COUNSELING	0	260		90.02
91.00	09100	EMERGENCY	0	732,294		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0			92.00
		OTHER REIMBURSABLE COST CENTERS				
102.00	10200	OPIOID TREATMENT PROGRAM	0	0		102.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	7,486,620		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	58,146		190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	1,372		192.00
194.00	07950	COMMUNITY RELATIONS & MARKETING	0	0		194.00
194.01	07951	PLAINFIELD RADIOLOGY & PHYSICAL THE	0	2,245		194.01
194.02	07952	JV MV ENDOSCOPY	0	0		194.02
194.03	07953	SOUTHWEST CENTER FOR WOMENS HEALTH	0	0		194.03
194.04	07954	OTHER NRCC	0	3,142,621		194.04
200.00		Cross Foot Adjustments	0	0		200.00
201.00		Negative Cost Centers	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	0	10,691,004		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0057 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/31/2024 10:46 am

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	ADMITTING (INPATIENT CHARGES)	CASHIERING/ACCOUNTS RECEIVABLE (GROSS CHARGES)	
			1.00	2.00	4.00	5.01	5.02	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	291,711					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		291,711				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	25,490,553			4.00
5.01	00570	ADMITTING	2,843	2,843	0	131,279,936		5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	0	0	0	637,109,892	5.02
5.03	00590	OTHER ADMIN & GENERAL	10,723	10,723	734,936	0	0	5.03
7.00	00700	OPERATION OF PLANT	36,562	36,562	1,216,518	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,050	1,050	54,511	0	0	8.00
9.00	00900	HOUSEKEEPING	3,091	3,091	1,231,242	0	0	9.00
10.00	01000	DIETARY	4,321	4,321	130,918	0	0	10.00
11.00	01100	CAFETERIA	3,711	3,711	362,461	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	128	128	612,129	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,275	2,275	150,386	0	0	14.00
15.00	01500	PHARMACY	4,016	4,016	969,185	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	53,592	53,592	3,065,879	18,659,297	25,368,683	30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	8,804	8,804	1,642,489	5,684,805	5,684,805	34.00
43.00	04300	NURSERY	0	0	449,981	2,117,350	2,117,350	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	26,034	26,034	2,122,710	23,224,831	61,846,159	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	1,309,477	6,291,304	6,325,605	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,860	10,860	2,195,278	5,790,348	75,792,561	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	8,224	8,224	520,743	323,202	34,086,677	55.00
60.00	06000	LABORATORY	4,683	4,683	0	10,029,651	47,754,790	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	946,457	882,070	21,898,354	64.00
65.00	06500	RESPIRATORY THERAPY	2,061	2,061	1,174,289	3,875,456	8,412,987	65.00
66.00	06600	PHYSICAL THERAPY	8,440	8,440	1,612,692	2,547,492	15,731,002	66.00
67.00	06700	OCCUPATIONAL THERAPY	4,919	4,919	225,318	277,570	2,110,601	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	63,640	317,194	597,573	68.00
69.00	06900	ELECTROCARDIOLOGY	3,690	3,690	324,345	1,740,423	18,758,655	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	4,004	4,004	13,555	142,471	2,497,579	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	13,264,329	33,874,623	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	14,343,730	41,682,327	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	9,443,937	114,197,624	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CARE INSTITUTE	0	0	8,269	0	5,207	90.01
90.02	09002	OP NUTRITIONAL COUNSELING	0	0	59,271	0	71,641	90.02
91.00	09100	EMERGENCY	15,303	15,303	3,788,464	12,324,476	118,295,089	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	219,334	219,334	24,985,143	131,279,936	637,109,892	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	1,329	1,329	42,019	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	212,873	0	0	192.00
194.00	07950	COMMUNITY RELATIONS & MARKETING	0	0	0	0	0	194.00
194.01	07951	PLAINFIELD RADIOLOGY & PHYSICAL THE	0	0	235,435	0	0	194.01
194.02	07952	JV MV ENDOSCOPY	0	0	0	0	0	194.02
194.03	07953	SOUTHWEST CENTER FOR WOMENS HEALTH	0	0	0	0	0	194.03
194.04	07954	OTHER NRCC	71,048	71,048	15,083	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	7,480,312	3,210,692	6,949,279	104,399	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	25.642886	11.006414	0.272622	0.000795	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			0	104,194	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000000	0.000794	0.000000	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0057 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/31/2024 10:46 am

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	ADMITTING (INPATIENT CHARGES)	CASHIERING/ACCOUNTS RECEIVABLE (GROSS CHARGES)	
			1.00	2.00	4.00	5.01	5.02	
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: 15-0057 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/31/2024 10:46 am

		Cost Center Description	Reconciliation	OTHER ADMIN & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	
			5A.03	5.03	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.02
5.03	00590	OTHER ADMIN & GENERAL	-23,322,971	114,157,636				5.03
7.00	00700	OPERATION OF PLANT	0	6,619,532	241,583			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	338,704	1,050	374,209		8.00
9.00	00900	HOUSEKEEPING	0	2,361,559	3,091	0	237,442	9.00
10.00	01000	DIETARY	0	428,502	4,321	0	4,321	10.00
11.00	01100	CAFETERIA	0	570,066	3,711	0	3,711	11.00
13.00	01300	NURSING ADMINISTRATION	0	848,831	128	0	128	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	385,580	2,275	0	2,275	14.00
15.00	01500	PHARMACY	0	1,533,758	4,016	0	4,016	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,020,372	0	0	0	16.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	8,401,237	53,592	102,054	53,592	30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	2,641,617	8,804	0	8,804	34.00
43.00	04300	NURSERY	0	579,907	0	23,101	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	3,904,292	26,034	50,880	26,034	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,688,298	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,702,929	10,860	43,863	10,860	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	3,326,709	8,224	252	8,224	55.00
60.00	06000	LABORATORY	0	3,607,605	4,683	0	4,683	60.00
64.00	06400	INTRAVENOUS THERAPY	0	1,305,004	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	1,568,244	2,061	0	2,061	65.00
66.00	06600	PHYSICAL THERAPY	0	2,370,171	8,440	9,164	8,440	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	469,341	4,919	2,613	4,919	67.00
68.00	06800	SPEECH PATHOLOGY	0	82,526	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	556,388	3,690	8,619	3,690	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	169,803	4,004	62	4,004	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	5,374,972	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	10,241,082	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	16,149,968	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CARE INSTITUTE	0	10,523	0	0	0	90.01
90.02	09002	OP NUTRITIONAL COUNSELING	0	75,500	0	0	0	90.02
91.00	09100	EMERGENCY	0	6,848,831	15,303	80,215	15,303	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-23,322,971	87,181,851	169,206	320,823	165,065	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	176,256	1,329	0	1,329	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	328,069	0	1,986	0	192.00
194.00	07950	COMMUNITY RELATIONS & MARKETING	0	0	0	0	0	194.00
194.01	07951	PLAINFIELD RADIOLOGY & PHYSICAL THE	0	310,140	0	0	0	194.01
194.02	07952	JV MV ENDOSCOPY	0	0	0	0	0	194.02
194.03	07953	SOUTHWEST CENTER FOR WOMENS HEALTH	0	0	0	0	0	194.03
194.04	07954	OTHER NRCC	0	26,161,320	71,048	51,400	71,048	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)		23,322,971	7,971,935	442,552	2,946,036	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)		0.204305	32.998742	1.182633	12.407392	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		392,991	1,362,763	45,571	138,850	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.003443	5.640972	0.121780	0.584774	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: 15-0057 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/31/2024 10:46 am

		Cost Center Description	DIETARY (GROSS PATIENT DAYS)	CAFETERIA (FTES)	NURSING ADMINISTRATION (DIRECT NUR SING)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
			10.00	11.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.02
5.03	00590	OTHER ADMIN & GENERAL						5.03
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	7,827					10.00
11.00	01100	CAFETERIA	0	673,994				11.00
13.00	01300	NURSING ADMINISTRATION	0	14,754	186,685			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	6,330	0	16,300,746		14.00
15.00	01500	PHARMACY	0	27,185	0	11,267	16,141,830	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,888	190,724	66,272	41,103	0	30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	1,307	0	0	8,245	0	34.00
43.00	04300	NURSERY	632	58,042	25,902	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	78,079	20,769	150,838	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	55	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	77,366	0	24,282	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	3,328	0	55.00
60.00	06000	LABORATORY	0	0	0	111	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	16,445	9,055	9,677	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	28,826	0	1,811	0	65.00
66.00	06600	PHYSICAL THERAPY	0	36,587	0	9,769	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	4,283	0	1,501	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	1,248	0	18	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	7,783	0	1,513	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	245	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	5,646,187	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	10,357,327	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	16,141,830	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CARE INSTITUTE	0	0	0	0	0	90.01
90.02	09002	OP NUTRITIONAL COUNSELING	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	0	118,666	64,687	23,661	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	7,827	666,318	186,685	16,290,938	16,141,830	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	2,273	0	2,450	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	COMMUNITY RELATIONS & MARKETING	0	0	0	0	0	194.00
194.01	07951	PLAINFIELD RADIOLOGY & PHYSICAL THE	0	4,885	0	1,612	0	194.01
194.02	07952	JV MV ENDOSCOPY	0	0	0	0	0	194.02
194.03	07953	SOUTHWEST CENTER FOR WOMENS HEALTH	0	0	0	0	0	194.03
194.04	07954	OTHER NRCC	0	518	0	5,746	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	712,247	855,035	1,046,780	575,685	2,064,348	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	90.998722	1.268609	5.607199	0.035316	0.127888	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	186,739	161,073	11,937	100,382	184,033	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	23.858311	0.238983	0.063942	0.006158	0.011401	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0057 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/31/2024 10:46 am

		Cost Center Description	DIETARY (GROSS PATIENT DAYS)	CAFETERIA (FTES)	NURSING ADMINISTRATION (DIRECT NURSING)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
			10.00	11.00	13.00	14.00	15.00	
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0057 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/31/2024 10:46 am

		Cost Center Description	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES APPRV (ASSIGNED TIME)	INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS APPRV (ASSIGNED TIME)		
			16.00	21.00	22.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00570	ADMITTING					5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE					5.02
5.03	00590	OTHER ADMIN & GENERAL					5.03
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	637,109,892				16.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0		0		22.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	25,368,683	0	0		30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	5,684,805	0	0		34.00
43.00	04300	NURSERY	2,117,350	0	0		43.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	61,846,159	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	6,325,605	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	75,792,561	0	0		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	34,086,677	0	0		55.00
60.00	06000	LABORATORY	47,754,790	0	0		60.00
64.00	06400	INTRAVENOUS THERAPY	21,898,354	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	8,412,987	0	0		65.00
66.00	06600	PHYSICAL THERAPY	15,731,002	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	2,110,601	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	597,573	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	18,758,655	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	2,497,579	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	33,874,623	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	41,682,327	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	114,197,624	0	0		73.00
74.00	07400	RENAL DIALYSIS	0	0	0		74.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0		78.00
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	0		90.00
90.01	09001	WOUND CARE INSTITUTE	5,207	0	0		90.01
90.02	09002	OP NUTRITIONAL COUNSELING	71,641	0	0		90.02
91.00	09100	EMERGENCY	118,295,089	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
		OTHER REIMBURSABLE COST CENTERS					
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0		102.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	637,109,892	0	0		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0		190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0		192.00
194.00	07950	COMMUNITY RELATIONS & MARKETING	0	0	0		194.00
194.01	07951	PLAINFIELD RADIOLOGY & PHYSICAL THE	0	0	0		194.01
194.02	07952	JV MV ENDOSCOPY	0	0	0		194.02
194.03	07953	SOUTHWEST CENTER FOR WOMENS HEALTH	0	0	0		194.03
194.04	07954	OTHER NRCC	0	0	0		194.04
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,228,839	0	0		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.001929	0.000000	0.000000		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	3,513	0	0		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000006	0.000000	0.000000		205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0057 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/31/2024 10:46 am

		Cost Center Description	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES APPRV (ASSIGNED TIME)	INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS APPRV (ASSIGNED TIME)		
			16.00	21.00	22.00		
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)					206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)					207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0057 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 5/31/2024 10:46 am

Title XVIII | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	Costs RCE Disallowance	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	13,871,494		13,871,494	0	13,871,494	30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	3,711,261		3,711,261	0	3,711,261	34.00
43.00	04300	NURSERY	1,006,171		1,006,171	0	1,006,171	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,284,369		6,284,369	0	6,284,369	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,045,430		2,045,430	0	2,045,430	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,249,649		5,249,649	0	5,249,649	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	4,445,961		4,445,961	0	4,445,961	55.00
60.00	06000	LABORATORY	4,649,417		4,649,417	0	4,649,417	60.00
64.00	06400	INTRAVENOUS THERAPY	1,685,842		1,685,842	0	1,685,842	64.00
65.00	06500	RESPIRATORY THERAPY	2,035,088	0	2,035,088	0	2,035,088	65.00
66.00	06600	PHYSICAL THERAPY	3,325,579	0	3,325,579	0	3,325,579	66.00
67.00	06700	OCCUPATIONAL THERAPY	801,230	0	801,230	0	801,230	67.00
68.00	06800	SPEECH PATHOLOGY	102,123	0	102,123	0	102,123	68.00
69.00	06900	ELECTROCARDIOLOGY	893,914		893,914	0	893,914	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	391,201		391,201	0	391,201	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	6,737,851		6,737,851	0	6,737,851	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	12,779,575		12,779,575	0	12,779,575	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	21,734,122		21,734,122	0	21,734,122	73.00
74.00	07400	RENAL DIALYSIS	0		0	0	0	74.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0		0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0		0	0	0	90.00
90.01	09001	WOUND CARE INSTITUTE	12,683		12,683	0	12,683	90.01
90.02	09002	OP NUTRITIONAL COUNSELING	91,063		91,063	0	91,063	90.02
91.00	09100	EMERGENCY	9,779,933		9,779,933	0	9,779,933	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,728,884		2,728,884		2,728,884	92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0		0		0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	104,362,840	0	104,362,840	0	104,362,840	200.00
201.00		Less Observation Beds	2,728,884		2,728,884		2,728,884	201.00
202.00		Total (see instructions)	101,633,956	0	101,633,956	0	101,633,956	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0057 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 5/31/2024 10:46 am

Title XVIII | Hospital | PPS

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	17,277,071		17,277,071			30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	5,684,805		5,684,805			34.00
43.00	04300	NURSERY	2,117,350		2,117,350			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	23,224,831	38,621,328	61,846,159	0.101613	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	6,291,304	34,301	6,325,605	0.323357	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,790,348	70,002,213	75,792,561	0.069263	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	323,202	33,763,475	34,086,677	0.130431	0.000000	55.00
60.00	06000	LABORATORY	10,029,651	37,725,139	47,754,790	0.097360	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	882,070	21,016,284	21,898,354	0.076985	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	3,875,456	4,537,531	8,412,987	0.241898	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	2,547,492	13,183,510	15,731,002	0.211403	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	277,570	1,833,031	2,110,601	0.379622	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	317,194	280,379	597,573	0.170896	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	1,740,423	17,018,232	18,758,655	0.047653	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	142,471	2,355,108	2,497,579	0.156632	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	13,264,329	20,610,294	33,874,623	0.198906	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	14,343,730	27,338,597	41,682,327	0.306595	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	9,443,937	104,753,687	114,197,624	0.190320	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0.000000	0.000000	74.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0.000000	0.000000	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
90.01	09001	WOUND CARE INSTITUTE	0	5,207	5,207	2.435760	0.000000	90.01
90.02	09002	OP NUTRITIONAL COUNSELING	0	71,641	71,641	1.271102	0.000000	90.02
91.00	09100	EMERGENCY	12,324,476	105,970,613	118,295,089	0.082674	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,382,226	6,709,386	8,091,612	0.337248	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0			102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	131,279,936	505,829,956	637,109,892			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	131,279,936	505,829,956	637,109,892			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0057 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 5/31/2024 10:46 am

Title XVIII | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT		34.00
43.00	04300	NURSERY		43.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.101613	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.323357	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.069263	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.130431	55.00
60.00	06000	LABORATORY	0.097360	60.00
64.00	06400	INTRAVENOUS THERAPY	0.076985	64.00
65.00	06500	RESPIRATORY THERAPY	0.241898	65.00
66.00	06600	PHYSICAL THERAPY	0.211403	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.379622	67.00
68.00	06800	SPEECH PATHOLOGY	0.170896	68.00
69.00	06900	ELECTROCARDIOLOGY	0.047653	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.156632	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.198906	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.306595	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.190320	73.00
74.00	07400	RENAL DIALYSIS	0.000000	74.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000	78.00
		OUTPATIENT SERVICE COST CENTERS		
90.00	09000	CLINIC	0.000000	90.00
90.01	09001	WOUND CARE INSTITUTE	2.435760	90.01
90.02	09002	OP NUTRITIONAL COUNSELING	1.271102	90.02
91.00	09100	EMERGENCY	0.082674	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.337248	92.00
		OTHER REIMBURSABLE COST CENTERS		
102.00	10200	OPIOID TREATMENT PROGRAM		102.00
		SPECIAL PURPOSE COST CENTERS		
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: 15-0057 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 5/31/2024 10:46 am

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	Costs RCE Disallowance	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	13,871,494		13,871,494	0	13,871,494	30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	3,711,261		3,711,261	0	3,711,261	34.00
43.00	04300	NURSERY	1,006,171		1,006,171	0	1,006,171	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,284,369		6,284,369	0	6,284,369	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,045,430		2,045,430	0	2,045,430	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,249,649		5,249,649	0	5,249,649	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	4,445,961		4,445,961	0	4,445,961	55.00
60.00	06000	LABORATORY	4,649,417		4,649,417	0	4,649,417	60.00
64.00	06400	INTRAVENOUS THERAPY	1,685,842		1,685,842	0	1,685,842	64.00
65.00	06500	RESPIRATORY THERAPY	2,035,088	0	2,035,088	0	2,035,088	65.00
66.00	06600	PHYSICAL THERAPY	3,325,579	0	3,325,579	0	3,325,579	66.00
67.00	06700	OCCUPATIONAL THERAPY	801,230	0	801,230	0	801,230	67.00
68.00	06800	SPEECH PATHOLOGY	102,123	0	102,123	0	102,123	68.00
69.00	06900	ELECTROCARDIOLOGY	893,914		893,914	0	893,914	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	391,201		391,201	0	391,201	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	6,737,851		6,737,851	0	6,737,851	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	12,779,575		12,779,575	0	12,779,575	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	21,734,122		21,734,122	0	21,734,122	73.00
74.00	07400	RENAL DIALYSIS	0		0	0	0	74.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0		0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0		0	0	0	90.00
90.01	09001	WOUND CARE INSTITUTE	12,683		12,683	0	12,683	90.01
90.02	09002	OP NUTRITIONAL COUNSELING	91,063		91,063	0	91,063	90.02
91.00	09100	EMERGENCY	9,779,933		9,779,933	0	9,779,933	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,728,884		2,728,884		2,728,884	92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0		0		0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	104,362,840	0	104,362,840	0	104,362,840	200.00
201.00		Less Observation Beds	2,728,884		2,728,884		2,728,884	201.00
202.00		Total (see instructions)	101,633,956	0	101,633,956	0	101,633,956	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0057 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 5/31/2024 10:46 am

Title XIX | Hospital | PPS

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	17,277,071		17,277,071			30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	5,684,805		5,684,805			34.00
43.00	04300	NURSERY	2,117,350		2,117,350			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	23,224,831	38,621,328	61,846,159	0.101613	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	6,291,304	34,301	6,325,605	0.323357	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,790,348	70,002,213	75,792,561	0.069263	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	323,202	33,763,475	34,086,677	0.130431	0.000000	55.00
60.00	06000	LABORATORY	10,029,651	37,725,139	47,754,790	0.097360	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	882,070	21,016,284	21,898,354	0.076985	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	3,875,456	4,537,531	8,412,987	0.241898	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	2,547,492	13,183,510	15,731,002	0.211403	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	277,570	1,833,031	2,110,601	0.379622	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	317,194	280,379	597,573	0.170896	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	1,740,423	17,018,232	18,758,655	0.047653	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	142,471	2,355,108	2,497,579	0.156632	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	13,264,329	20,610,294	33,874,623	0.198906	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	14,343,730	27,338,597	41,682,327	0.306595	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	9,443,937	104,753,687	114,197,624	0.190320	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0.000000	0.000000	74.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0.000000	0.000000	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
90.01	09001	WOUND CARE INSTITUTE	0	5,207	5,207	2.435760	0.000000	90.01
90.02	09002	OP NUTRITIONAL COUNSELING	0	71,641	71,641	1.271102	0.000000	90.02
91.00	09100	EMERGENCY	12,324,476	105,970,613	118,295,089	0.082674	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,382,226	6,709,386	8,091,612	0.337248	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0			102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	131,279,936	505,829,956	637,109,892			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	131,279,936	505,829,956	637,109,892			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0057 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 5/31/2024 10:46 am

Title XIX | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT		34.00
43.00	04300	NURSERY		43.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.101613	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.323357	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.069263	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.130431	55.00
60.00	06000	LABORATORY	0.097360	60.00
64.00	06400	INTRAVENOUS THERAPY	0.076985	64.00
65.00	06500	RESPIRATORY THERAPY	0.241898	65.00
66.00	06600	PHYSICAL THERAPY	0.211403	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.379622	67.00
68.00	06800	SPEECH PATHOLOGY	0.170896	68.00
69.00	06900	ELECTROCARDIOLOGY	0.047653	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.156632	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.198906	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.306595	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.190320	73.00
74.00	07400	RENAL DIALYSIS	0.000000	74.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000	78.00
		OUTPATIENT SERVICE COST CENTERS		
90.00	09000	CLINIC	0.000000	90.00
90.01	09001	WOUND CARE INSTITUTE	2.435760	90.01
90.02	09002	OP NUTRITIONAL COUNSELING	1.271102	90.02
91.00	09100	EMERGENCY	0.082674	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.337248	92.00
		OTHER REIMBURSABLE COST CENTERS		
102.00	10200	OPIOID TREATMENT PROGRAM		102.00
		SPECIAL PURPOSE COST CENTERS		
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

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

Provider CCN: 15-0057 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part II | Date/Time Prepared: 5/31/2024 10:46 am

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,284,369	1,175,533	5,108,836	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,045,430	10,846	2,034,584	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,249,649	507,407	4,742,242	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	4,445,961	364,571	4,081,390	0	0	55.00
60.00	06000	LABORATORY	4,649,417	221,457	4,427,960	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	1,685,842	9,893	1,675,949	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	2,035,088	103,791	1,931,297	0	0	65.00
66.00	06600	PHYSICAL THERAPY	3,325,579	382,062	2,943,517	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	801,230	214,103	587,127	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	102,123	838	101,285	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	893,914	164,539	729,375	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	391,201	172,394	218,807	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	6,737,851	64,010	6,673,841	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	12,779,575	110,682	12,668,893	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	21,734,122	247,820	21,486,302	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CARE INSTITUTE	12,683	36	12,647	0	0	90.01
90.02	09002	OP NUTRITIONAL COUNSELING	91,063	260	90,803	0	0	90.02
91.00	09100	EMERGENCY	9,779,933	732,294	9,047,639	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,728,884	500,595	2,228,289	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (sum of lines 50 thru 199)	85,773,914	4,983,131	80,790,783	0	0	200.00
201.00		Less Observation Beds	2,728,884	500,595	2,228,289	0	0	201.00
202.00		Total (line 200 minus line 201)	83,045,030	4,482,536	78,562,494	0	0	202.00

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

Provider CCN: 15-0057 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part II Date/Time Prepared: 5/31/2024 10:46 am

Title XIX | Hospital | PPS

		Cost Center Description	Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)		
			6.00	7.00	8.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	6,284,369	61,846,159	0.101613		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,045,430	6,325,605	0.323357		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,249,649	75,792,561	0.069263		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	4,445,961	34,086,677	0.130431		55.00
60.00	06000	LABORATORY	4,649,417	47,754,790	0.097360		60.00
64.00	06400	INTRAVENOUS THERAPY	1,685,842	21,898,354	0.076985		64.00
65.00	06500	RESPIRATORY THERAPY	2,035,088	8,412,987	0.241898		65.00
66.00	06600	PHYSICAL THERAPY	3,325,579	15,731,002	0.211403		66.00
67.00	06700	OCCUPATIONAL THERAPY	801,230	2,110,601	0.379622		67.00
68.00	06800	SPEECH PATHOLOGY	102,123	597,573	0.170896		68.00
69.00	06900	ELECTROCARDIOLOGY	893,914	18,758,655	0.047653		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	391,201	2,497,579	0.156632		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	6,737,851	33,874,623	0.198906		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	12,779,575	41,682,327	0.306595		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	21,734,122	114,197,624	0.190320		73.00
74.00	07400	RENAL DIALYSIS	0	0	0.000000		74.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0.000000		78.00
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	0.000000		90.00
90.01	09001	WOUND CARE INSTITUTE	12,683	5,207	2.435760		90.01
90.02	09002	OP NUTRITIONAL COUNSELING	91,063	71,641	1.271102		90.02
91.00	09100	EMERGENCY	9,779,933	118,295,089	0.082674		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,728,884	8,091,612	0.337248		92.00
		OTHER REIMBURSABLE COST CENTERS					
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0.000000		102.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (sum of lines 50 thru 199)	85,773,914	612,030,666			200.00
201.00		Less Observation Beds	2,728,884	0			201.00
202.00		Total (line 200 minus line 201)	83,045,030	612,030,666			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 15-0057 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part I Date/Time Prepared: 5/31/2024 10:46 am

Title XVIII | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	2,544,627	0	2,544,627	7,330	347.15	30.00
34.00	SURGICAL INTENSIVE CARE UNIT	422,348		422,348	1,307	323.14	34.00
43.00	NURSERY	37,109		37,109	632	58.72	43.00
200.00	Total (lines 30 through 199)	3,004,084		3,004,084	9,269		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)	
		6.00	7.00	
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS	1,957	679,373	30.00
34.00	SURGICAL INTENSIVE CARE UNIT	381	123,116	34.00
43.00	NURSERY	0	0	43.00
200.00	Total (lines 30 through 199)	2,338	802,489	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-0057 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part II Date/Time Prepared: 5/31/2024 10:46 am

Title XVIII | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,175,533	61,846,159	0.019007	8,210,550	156,058	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	10,846	6,325,605	0.001715	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	507,407	75,792,561	0.006695	2,065,849	13,831	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	364,571	34,086,677	0.010695	171,174	1,831	55.00
60.00	06000	LABORATORY	221,457	47,754,790	0.004637	2,872,424	13,319	60.00
64.00	06400	INTRAVENOUS THERAPY	9,893	21,898,354	0.000452	140,746	64	64.00
65.00	06500	RESPIRATORY THERAPY	103,791	8,412,987	0.012337	1,094,726	13,506	65.00
66.00	06600	PHYSICAL THERAPY	382,062	15,731,002	0.024287	1,138,607	27,653	66.00
67.00	06700	OCCUPATIONAL THERAPY	214,103	2,110,601	0.101442	99,469	10,090	67.00
68.00	06800	SPEECH PATHOLOGY	838	597,573	0.001402	41,657	58	68.00
69.00	06900	ELECTROCARDIOLOGY	164,539	18,758,655	0.008771	691,227	6,063	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	172,394	2,497,579	0.069024	26,955	1,861	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	64,010	33,874,623	0.001890	4,662,336	8,812	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	110,682	41,682,327	0.002655	6,903,871	18,330	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	247,820	114,197,624	0.002170	3,276,529	7,110	73.00
74.00	07400	RENAL DIALYSIS	0	0	0.000000	0	0	74.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0.000000	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
90.01	09001	WOUND CARE INSTITUTE	36	5,207	0.006914	0	0	90.01
90.02	09002	OP NUTRITIONAL COUNSELING	260	71,641	0.003629	0	0	90.02
91.00	09100	EMERGENCY	732,294	118,295,089	0.006190	4,162,683	25,767	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	500,595	8,091,612	0.061866	681,160	42,141	92.00
200.00		Total (lines 50 through 199)	4,983,131	612,030,666		36,239,963	346,494	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0057 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part III Date/Time Prepared: 5/31/2024 10:46 am

Title XVIII | Hospital | PPS

		Cost Center Description	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
			1A	1.00	2A	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
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	7,330	0.00	1,957	30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT		0	1,307	0.00	381	34.00
43.00	04300	NURSERY		0	632	0.00	0	43.00
200.00		Total (lines 30 through 199)		0	9,269		2,338	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
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	34.00
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: 15-0057 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV | Date/Time Prepared: 5/31/2024 10:46 am

Title XVIII | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO 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
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CARE INSTITUTE	0	0	0	0	0	90.01
90.02	09002	OP NUTRITIONAL COUNSELING	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0057 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV Date/Time Prepared: 5/31/2024 10:46 am

Title XVIII | Hospital | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	61,846,159	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	6,325,605	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	75,792,561	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	34,086,677	0.000000	55.00
60.00	06000	LABORATORY	0	0	0	47,754,790	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	21,898,354	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	8,412,987	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	15,731,002	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	2,110,601	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	597,573	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	18,758,655	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	2,497,579	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	33,874,623	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	41,682,327	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	114,197,624	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0.000000	74.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0.000000	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0.000000	90.00
90.01	09001	WOUND CARE INSTITUTE	0	0	0	5,207	0.000000	90.01
90.02	09002	OP NUTRITIONAL COUNSELING	0	0	0	71,641	0.000000	90.02
91.00	09100	EMERGENCY	0	0	0	118,295,089	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	8,091,612	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	612,030,666		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0057 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV | Date/Time Prepared: 5/31/2024 10:46 am

Title XVIII | Hospital | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	8,210,550	0	10,536,482	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	3,083	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	2,065,849	0	14,534,777	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	171,174	0	9,885,632	0	55.00
60.00	06000	LABORATORY	0.000000	2,872,424	0	1,638,671	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	140,746	0	3,402,944	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	1,094,726	0	1,110,206	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	1,138,607	0	612,670	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	99,469	0	25,859	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	41,657	0	1,470	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	691,227	0	4,530,160	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	26,955	0	290,407	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	4,662,336	0	11,648,848	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	6,903,871	0	2,310,377	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	3,276,529	0	45,030,251	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	WOUND CARE INSTITUTE	0.000000	0	0	2,759	0	90.01
90.02	09002	OP NUTRITIONAL COUNSELING	0.000000	0	0	0	0	90.02
91.00	09100	EMERGENCY	0.000000	4,162,683	0	14,191,707	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	681,160	0	858,744	0	92.00
200.00		Total (lines 50 through 199)		36,239,963	0	120,615,047	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0057 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part V Date/Time Prepared: 5/31/2024 10:46 am

Title XVIII | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.101613	10,536,482	0	0	1,070,644	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.323357	3,083	0	0	997	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.069263	14,534,777	0	0	1,006,722	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.130431	9,885,632	0	0	1,289,393	55.00
60.00	06000	LABORATORY	0.097360	1,638,671	0	0	159,541	60.00
64.00	06400	INTRAVENOUS THERAPY	0.076985	3,402,944	0	0	261,976	64.00
65.00	06500	RESPIRATORY THERAPY	0.241898	1,110,206	0	0	268,557	65.00
66.00	06600	PHYSICAL THERAPY	0.211403	612,670	0	0	129,520	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.379622	25,859	0	0	9,817	67.00
68.00	06800	SPEECH PATHOLOGY	0.170896	1,470	0	0	251	68.00
69.00	06900	ELECTROCARDIOLOGY	0.047653	4,530,160	0	0	215,876	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.156632	290,407	0	0	45,487	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.198906	11,648,848	599	0	2,317,026	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.306595	2,310,377	0	0	708,350	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.190320	45,030,251	0	9,382	8,570,157	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	WOUND CARE INSTITUTE	2.435760	2,759	0	0	6,720	90.01
90.02	09002	OP NUTRITIONAL COUNSELING	1.271102	0	0	0	0	90.02
91.00	09100	EMERGENCY	0.082674	14,191,707	0	0	1,173,285	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.337248	858,744	0	0	289,610	92.00
200.00		Subtotal (see instructions)		120,615,047	599	9,382	17,523,929	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		120,615,047	599	9,382	17,523,929	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0057 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part V Date/Time Prepared: 5/31/2024 10:46 am

Title XVIII | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0		55.00
60.00	06000	LABORATORY	0	0		60.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	119	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,786		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0		78.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
90.01	09001	WOUND CARE INSTITUTE	0	0		90.01
90.02	09002	OP NUTRITIONAL COUNSELING	0	0		90.02
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)	119	1,786		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	119	1,786		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 15-0057 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part I Date/Time Prepared: 5/31/2024 10:46 am

Title XIX | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	2,544,627	0	2,544,627	7,330	347.15	30.00
34.00	SURGICAL INTENSIVE CARE UNIT	422,348		422,348	1,307	323.14	34.00
43.00	NURSERY	37,109		37,109	632	58.72	43.00
200.00	Total (lines 30 through 199)	3,004,084		3,004,084	9,269		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
		6.00	7.00				
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	33	11,456				30.00
34.00	SURGICAL INTENSIVE CARE UNIT	7	2,262				34.00
43.00	NURSERY	4	235				43.00
200.00	Total (lines 30 through 199)	44	13,953				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-0057 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part II Date/Time Prepared: 5/31/2024 10:46 am

Title XIX | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,175,533	61,846,159	0.019007	2,549,007	48,449	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	10,846	6,325,605	0.001715	2,870,888	4,924	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	507,407	75,792,561	0.006695	747,903	5,007	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	364,571	34,086,677	0.010695	15,448	165	55.00
60.00	06000	LABORATORY	221,457	47,754,790	0.004637	1,590,031	7,373	60.00
64.00	06400	INTRAVENOUS THERAPY	9,893	21,898,354	0.000452	41,392	19	64.00
65.00	06500	RESPIRATORY THERAPY	103,791	8,412,987	0.012337	519,656	6,411	65.00
66.00	06600	PHYSICAL THERAPY	382,062	15,731,002	0.024287	131,392	3,191	66.00
67.00	06700	OCCUPATIONAL THERAPY	214,103	2,110,601	0.101442	25,243	2,561	67.00
68.00	06800	SPEECH PATHOLOGY	838	597,573	0.001402	103,486	145	68.00
69.00	06900	ELECTROCARDIOLOGY	164,539	18,758,655	0.008771	154,947	1,359	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	172,394	2,497,579	0.069024	22,151	1,529	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	64,010	33,874,623	0.001890	1,130,076	2,136	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	110,682	41,682,327	0.002655	368,574	979	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	247,820	114,197,624	0.002170	1,573,655	3,415	73.00
74.00	07400	RENAL DIALYSIS	0	0	0.000000	0	0	74.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0.000000	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
90.01	09001	WOUND CARE INSTITUTE	36	5,207	0.006914	0	0	90.01
90.02	09002	OP NUTRITIONAL COUNSELING	260	71,641	0.003629	0	0	90.02
91.00	09100	EMERGENCY	732,294	118,295,089	0.006190	1,671,897	10,349	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	500,595	8,091,612	0.061866	102,147	6,319	92.00
200.00		Total (lines 50 through 199)	4,983,131	612,030,666		13,617,893	104,331	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0057 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part III Date/Time Prepared: 5/31/2024 10:46 am

Title XIX | Hospital | PPS

		Cost Center Description	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
			1A	1.00	2A	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
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	7,330	0.00	33	30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT		0	1,307	0.00	7	34.00
43.00	04300	NURSERY		0	632	0.00	4	43.00
200.00		Total (lines 30 through 199)		0	9,269		44	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
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	34.00
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: 15-0057 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV | Date/Time Prepared: 5/31/2024 10:46 am

Title XIX | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO 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
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CARE INSTITUTE	0	0	0	0	0	90.01
90.02	09002	OP NUTRITIONAL COUNSELING	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0057 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV Date/Time Prepared: 5/31/2024 10:46 am

Title XIX | Hospital | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	61,846,159	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	6,325,605	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	75,792,561	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	34,086,677	0.000000	55.00
60.00	06000	LABORATORY	0	0	0	47,754,790	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	21,898,354	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	8,412,987	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	15,731,002	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	2,110,601	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	597,573	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	18,758,655	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	2,497,579	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	33,874,623	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	41,682,327	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	114,197,624	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0.000000	74.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0.000000	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0.000000	90.00
90.01	09001	WOUND CARE INSTITUTE	0	0	0	5,207	0.000000	90.01
90.02	09002	OP NUTRITIONAL COUNSELING	0	0	0	71,641	0.000000	90.02
91.00	09100	EMERGENCY	0	0	0	118,295,089	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	8,091,612	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	612,030,666		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0057 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV | Date/Time Prepared: 5/31/2024 10:46 am

Title XIX | Hospital | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	2,549,007	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	2,870,888	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	747,903	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	15,448	0	0	0	55.00
60.00	06000	LABORATORY	0.000000	1,590,031	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	41,392	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	519,656	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	131,392	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	25,243	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	103,486	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	154,947	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	22,151	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	1,130,076	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	368,574	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	1,573,655	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	WOUND CARE INSTITUTE	0.000000	0	0	0	0	90.01
90.02	09002	OP NUTRITIONAL COUNSELING	0.000000	0	0	0	0	90.02
91.00	09100	EMERGENCY	0.000000	1,671,897	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	102,147	0	0	0	92.00
200.00		Total (lines 50 through 199)		13,617,893	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0057 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part V Date/Time Prepared: 5/31/2024 10:46 am

Title XIX | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.101613	0	4,134,258	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.323357	0	31,218	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.069263	0	12,516,552	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.130431	0	3,345,775	0	0	55.00
60.00	06000	LABORATORY	0.097360	0	6,952,614	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.076985	0	1,108,043	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.241898	0	725,731	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.211403	0	1,582,182	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.379622	0	209,546	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.170896	0	45,401	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.047653	0	1,444,634	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.156632	0	613,415	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.198906	0	2,404,033	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.306595	0	2,040,680	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.190320	0	4,375,707	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	WOUND CARE INSTITUTE	2.435760	0	1,604	0	0	90.01
90.02	09002	OP NUTRITIONAL COUNSELING	1.271102	0	5,195	0	0	90.02
91.00	09100	EMERGENCY	0.082674	0	37,082,250	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.337248	0	754,830	0	0	92.00
200.00		Subtotal (see instructions)		0	79,373,668	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	79,373,668	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0057 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part V Date/Time Prepared: 5/31/2024 10:46 am

Title XIX | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	420,094	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	10,095	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	866,934	0		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	436,393	0		55.00
60.00	06000	LABORATORY	676,906	0		60.00
64.00	06400	INTRAVENOUS THERAPY	85,303	0		64.00
65.00	06500	RESPIRATORY THERAPY	175,553	0		65.00
66.00	06600	PHYSICAL THERAPY	334,478	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	79,548	0		67.00
68.00	06800	SPEECH PATHOLOGY	7,759	0		68.00
69.00	06900	ELECTROCARDIOLOGY	68,841	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	96,080	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	478,177	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	625,662	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	832,785	0		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0		78.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
90.01	09001	WOUND CARE INSTITUTE	3,907	0		90.01
90.02	09002	OP NUTRITIONAL COUNSELING	6,603	0		90.02
91.00	09100	EMERGENCY	3,065,738	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	254,565	0		92.00
200.00		Subtotal (see instructions)	8,525,421	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	8,525,421	0		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0057 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/31/2024 10:46 am

Title XVIII | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	7,330	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	7,330	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)	5,888	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	1,957	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	13,871,494	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)	13,871,494	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	13,871,494	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,892.43	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	3,703,486	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)	3,703,486	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0057 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/31/2024 10:46 am

Title XVIII | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT	3,711,261	1,307	2,839.53	381	1,081,861	46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	6,119,278	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)	10,904,625	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)	802,489	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	346,494	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	1,148,983	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	9,755,642	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)	1,442	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,892.43	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	2,728,884	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0057 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/31/2024 10:46 am

Title XVIII | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	2,544,627	13,871,494	0.183443	2,728,884	500,595	90.00
91.00	Nursing Program cost	0	13,871,494	0.000000	2,728,884	0	91.00
92.00	Allied health cost	0	13,871,494	0.000000	2,728,884	0	92.00
93.00	All other Medical Education	0	13,871,494	0.000000	2,728,884	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0057 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/31/2024 10:46 am

Title XIX | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	7,330	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	7,330	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)	5,888	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)	33	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)	632	15.00
16.00	Nursery days (title V or XIX only)	4	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	13,871,494	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)	13,871,494	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	13,871,494	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,892.43	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	62,450	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)	62,450	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0057 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/31/2024 10:46 am

Title XIX | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	1,006,171	632	1,592.04	4	6,368	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT	3,711,261	1,307	2,839.53	7	19,877	46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	2,400,697	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)	2,489,392	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)	13,953	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	104,331	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	118,284	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	2,371,108	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)	1,442	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,892.43	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	2,728,884	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0057 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/31/2024 10:46 am

Title XIX | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	2,544,627	13,871,494	0.183443	2,728,884	500,595	90.00
91.00	Nursing Program cost	0	13,871,494	0.000000	2,728,884	0	91.00
92.00	Allied health cost	0	13,871,494	0.000000	2,728,884	0	92.00
93.00	All other Medical Education	0	13,871,494	0.000000	2,728,884	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0057 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-3 | Date/Time Prepared: 5/31/2024 10:46 am

Title XVIII | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		5,503,800		30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT		1,538,736		34.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.101613	8,210,550	834,299	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.323357	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.069263	2,065,849	143,087	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.130431	171,174	22,326	55.00
60.00	06000	LABORATORY	0.097360	2,872,424	279,659	60.00
64.00	06400	INTRAVENOUS THERAPY	0.076985	140,746	10,835	64.00
65.00	06500	RESPIRATORY THERAPY	0.241898	1,094,726	264,812	65.00
66.00	06600	PHYSICAL THERAPY	0.211403	1,138,607	240,705	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.379622	99,469	37,761	67.00
68.00	06800	SPEECH PATHOLOGY	0.170896	41,657	7,119	68.00
69.00	06900	ELECTROCARDIOLOGY	0.047653	691,227	32,939	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.156632	26,955	4,222	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.198906	4,662,336	927,367	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.306595	6,903,871	2,116,692	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.190320	3,276,529	623,589	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	74.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	0	0	90.00
90.01	09001	WOUND CARE INSTITUTE	2.435760	0	0	90.01
90.02	09002	OP NUTRITIONAL COUNSELING	1.271102	0	0	90.02
91.00	09100	EMERGENCY	0.082674	4,162,683	344,146	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.337248	681,160	229,720	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		36,239,963	6,119,278	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)		36,239,963		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0057 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-3 | Date/Time Prepared: 5/31/2024 10:46 am

Title XIX | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		2,305,127		30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT		987,920		34.00
43.00	04300	NURSERY		1,340,370		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.101613	2,549,007	259,012	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.323357	2,870,888	928,322	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.069263	747,903	51,802	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.130431	15,448	2,015	55.00
60.00	06000	LABORATORY	0.097360	1,590,031	154,805	60.00
64.00	06400	INTRAVENOUS THERAPY	0.076985	41,392	3,187	64.00
65.00	06500	RESPIRATORY THERAPY	0.241898	519,656	125,704	65.00
66.00	06600	PHYSICAL THERAPY	0.211403	131,392	27,777	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.379622	25,243	9,583	67.00
68.00	06800	SPEECH PATHOLOGY	0.170896	103,486	17,685	68.00
69.00	06900	ELECTROCARDIOLOGY	0.047653	154,947	7,384	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.156632	22,151	3,470	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.198906	1,130,076	224,779	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.306595	368,574	113,003	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.190320	1,573,655	299,498	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	74.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	0	0	90.00
90.01	09001	WOUND CARE INSTITUTE	2.435760	0	0	90.01
90.02	09002	OP NUTRITIONAL COUNSELING	1.271102	0	0	90.02
91.00	09100	EMERGENCY	0.082674	1,671,897	138,222	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.337248	102,147	34,449	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		13,617,893	2,400,697	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)		13,617,893		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0057	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part A Date/Time Prepared: 5/31/2024 10:46 am
	Title XVIII	Hospital	PPS

		1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS		
1.00	DRG Amounts Other than Outlier Payments	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	5,998,232	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	1,781,552	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)	82,123	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)	0	2.04
3.00	Managed Care Simulated Payments	0	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	76.05	4.00
	Indirect Medical Education Adjustment		
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)	0.00	5.00
5.01	FTE cap adjustment for qualifing hospitals under §131 of the CAA 2021 (see instructions)	0.00	5.01
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)	0.00	6.00
6.26	Rural track program FTE cap limitation adjustment after the cap-building window closed under §127 of the CAA 2021 (see instructions)	0.00	6.26
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)	0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.	0.00	7.01
7.02	Adjustment (increase or decrease) to the hospital's rural track program FTE limitation(s) for rural track programs with a rural track for Medicare GME affiliated programs in accordance with 413.75(b) and 87 FR 49075 (August 10, 2022) (see instructions)	0.00	7.02
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).	0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.	0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)	0.00	8.02
8.21	The amount of increase if the hospital was awarded FTE cap slots under §126 of the CAA 2021 (see instructions)	0.00	8.21
9.00	Sum of lines 5 and 5.01, plus line 6, plus lines 6.26 through 6.49, minus lines 7 and 7.01, plus or minus line 7.02, plus/minus line 8, plus lines 8.01 through 8.27 (see instructions)	0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records	0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.	0.00	11.00
12.00	Current year allowable FTE (see instructions)	0.00	12.00
13.00	Total allowable FTE count for the prior year.	0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.	0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.	0.00	15.00
16.00	Adjustment for residents in initial years of the program (see instructions)	0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure	0.00	17.00
18.00	Adjusted rolling average FTE count	0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).	0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)	0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)	0.000000	21.00
22.00	IME payment adjustment (see instructions)	0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)	0	22.01
	Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA		
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).	0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)	0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)	0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)	0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)	0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)	0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)	0	28.01
29.00	Total IME payment (sum of lines 22 and 28)	0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	0	29.01
	Disproportionate Share Adjustment		
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	2.07	30.00
31.00	Percentage of Medicaid patient days (see instructions)	23.22	31.00
32.00	Sum of lines 30 and 31	25.29	32.00
33.00	Allowable disproportionate share percentage (see instructions)	10.08	33.00
34.00	Disproportionate share adjustment (see instructions)	196,051	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0057	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part A Date/Time Prepared: 5/31/2024 10:46 am
	Title XVIII	Hospital	PPS

		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	Uncompensated Care Payment Adjustment			
35.00	Total uncompensated care amount (see instructions)	6,874,403,459	5,938,006,757	35.00
35.01	Factor 3 (see instructions)	0.000251949	0.000226737	35.01
35.02	Hospital UCP, including supplemental UCP (see instructions)	1,731,996	1,346,364	35.02
35.03	Pro rata share of the hospital UCP, including supplemental UCP (see instructions)	1,295,438	338,430	35.03
36.00	Total UCP adjustment (sum of columns 1 and 2 on line 35.03)	1,633,868		36.00
	Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)			
40.00	Total Medicare discharges (see instructions)	0		40.00
41.00	Total ESRD Medicare discharges (see instructions)	0		41.00
41.01	Total ESRD Medicare covered and paid discharges (see instructions)	0		41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00		42.00
43.00	Total Medicare ESRD inpatient days (see instructions)	0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)	0		46.00
47.00	Subtotal (see instructions)	9,691,826		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)	0		48.00

		Amount	
		1.00	
49.00	Total payment for inpatient operating costs (see instructions)	9,691,826	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	593,252	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)	0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).	0	52.00
53.00	Nursing and Allied Health Managed Care payment	0	53.00
54.00	Special add-on payments for new technologies	7,595	54.00
54.01	Islet isolation add-on payment	0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)	0	55.00
55.01	Cellular therapy acquisition cost (see instructions)	0	55.01
56.00	Cost of physicians' services in a teaching hospital (see intructions)	0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).	0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)	0	58.00
59.00	Total (sum of amounts on lines 49 through 58)	10,292,673	59.00
60.00	Primary payer payments	10,381	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)	10,282,292	61.00
62.00	Deductibles billed to program beneficiaries	898,936	62.00
63.00	Coinsurance billed to program beneficiaries	2,400	63.00
64.00	Allowable bad debts (see instructions)	32,811	64.00
65.00	Adjusted reimbursable bad debts (see instructions)	21,327	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	3,200	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	9,402,283	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)	0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).(For SCH see instructions)	0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	70.00
70.50	Rural Community Hospital Demonstration Project (§410A Demonstration) adjustment (see instructions)	0	70.50
70.75	N95 respirator payment adjustment amount (see instructions)	0	70.75
70.87	Demonstration payment adjustment amount before sequestration	0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)	0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)	0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)	0	70.91
70.92	Bundled Model 1 discount amount (see instructions)	0	70.92
70.93	HVBP payment adjustment amount (see instructions)	7,343	70.93
70.94	HRR adjustment amount (see instructions)	-356	70.94
70.95	Recovery of accelerated depreciation	0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-0057 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E Part A Date/Time Prepared: 5/31/2024 10:46 am

Title XVIII | Hospital | PPS

		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	2022	945,562	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)	2023	269,310	70.97
70.98	Low Volume Payment-3	0	0	70.98
70.99	HAC adjustment amount (see instructions)		0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		10,624,142	71.00
71.01	Sequestration adjustment (see instructions)		212,483	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
71.03	Sequestration adjustment-PARHM pass-throughs			71.03
72.00	Interim payments		9,849,968	72.00
72.01	Interim payments-PARHM			72.01
73.00	Tentative settlement (for contractor use only)		0	73.00
73.01	Tentative settlement-PARHM (for contractor use only)			73.01
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)		561,691	74.00
74.01	Balance due provider/program-PARHM (see instructions)			74.01
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		163,710	75.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)			
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00

		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	HSP Bonus Payment Amount			
100.00	HSP bonus amount (see instructions)	0	0	100.00
	HVBP Adjustment for HSP Bonus Payment			
101.00	HVBP adjustment factor (see instructions)	0.0000000000	0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)	0	0	102.00
	HRR Adjustment for HSP Bonus Payment			
103.00	HRR adjustment factor (see instructions)	0.0000	0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)	0	0	104.00
	Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment			
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
	Cost Reimbursement			
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)			201.00
202.00	Medicare discharges (see instructions)			202.00
203.00	Case-mix adjustment factor (see instructions)			203.00
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)			
204.00	Medicare target amount			204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)			205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)			206.00
	Adjustment to Medicare Part A Inpatient Reimbursement			
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)			208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
211.00	Total adjustment to Medicare IPPS payments (see instructions)			211.00
	Comparision of PPS versus Cost Reimbursement			
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)			212.00
213.00	Low-volume adjustment (see instructions)			213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)			218.00

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 15-0057 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 5/31/2024 10:46 am

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	5,998,232	0	5,998,232		5,998,232	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	1,781,552	0		1,781,552	1,781,552	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	82,123	0	82,123		82,123	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	0	0		0	0	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	0	4.00
	Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
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	0	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0	9.01
	Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1008	0.1008	0.1008	0.1008		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	196,051	0	151,156	44,895	196,051	11.00
11.01	Uncompensated care payments	36.00	1,633,868	0	1,295,438	338,430	1,633,868	11.01
	Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	9,691,826	0	7,526,949	2,164,877	9,691,826	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	9,691,826	0	7,526,949	2,164,877	9,691,826	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	593,252	0	455,741	137,511	593,252	16.00

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 15-0057 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 5/31/2024 10:46 am

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	
17.00	Special add-on payments for new technologies	54.00	7,595	0	7,595	0	7,595	17.00
17.01	Net organ aquisition cost							17.01
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	7,990,285	2,302,388	10,292,673	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	589,416	0	451,905	137,511	589,416	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	3,836	0	3,836	0	3,836	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	0.0000	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	593,252	0	455,741	137,511	593,252	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				0.118339	0.116970		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			945,562		945,562	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				269,310	269,310	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: 15-0057 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 5/31/2024 10:46 am

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 (cols. 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	5,998,232	5,998,232		5,998,232	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	1,781,552		1,781,552	1,781,552	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	82,123	82,123		82,123	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	0		0	0	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	4.00
	Indirect Medical Education Adjustment						
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA						
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	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	9.01
	Disproportionate Share Adjustment						
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1008	0.1008	0.1008		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	196,051	151,156	44,895	196,051	11.00
11.01	Uncompensated care payments	36.00	1,633,868	1,295,438	338,430	1,633,868	11.01
	Additional payment for high percentage of ESRD beneficiary discharges						
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	9,691,826	7,526,949	2,164,877	9,691,826	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	9,691,826	7,526,949	2,164,877	9,691,826	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	593,252	455,741	137,511	593,252	16.00
17.00	Special add-on payments for new technologies	54.00	7,595	7,595	0	7,595	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	SUBTOTAL			7,990,285	2,302,388	10,292,673	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 15-0057 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 5/31/2024 10:46 am

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	589,416	451,905	137,511	589,416	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	3,836	3,836	0	3,836	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	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	593,252	455,741	137,511	593,252	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	945,562	945,562		945,562	28.00
29.00	Low volume adjustment on or after October 1	70.97	269,310		269,310	269,310	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	7,343	0	7,343	7,343	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0	0	0	0	30.01
31.00	HRR adjustment (see instructions)	70.94	-356	0	-356	-356	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0	0	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		0	0	0	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		N				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0057	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part B Date/Time Prepared: 5/31/2024 10:46 am
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	1,905	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	17,523,929	2.00
3.00	OPPS or REH payments	13,955,296	3.00
4.00	Outlier payment (see instructions)	0	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs including REH direct graduate medical education costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	1,905	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	9,981	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)	9,981	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	9,981	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	8,076	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)	1,905	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	13,955,296	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	120	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	2,323,243	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)	11,633,838	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)	11,633,838	30.00
31.00	Primary payer payments	621	31.00
32.00	Subtotal (line 30 minus line 31)	11,633,217	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33.00	Composite rate ESRD (from Wkst. I-5, line 11)	0	33.00
34.00	Allowable bad debts (see instructions)	162,709	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	105,761	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	80,647	36.00
37.00	Subtotal (see instructions)	11,738,978	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)	11,738,978	40.00
40.01	Sequestration adjustment (see instructions)	234,780	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	11,507,922	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)	-3,724	43.00
43.01	Balance due provider/program-PARHM (see instructions)		43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0057	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part B Date/Time Prepared: 5/31/2024 10:46 am
	Title XVIII	Hospital	PPS

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED | Provider CCN: 15-0057 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E-1 Part I | Date/Time Prepared: 5/31/2024 10:46 am

Title XVIII | Hospital | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		9,849,968		11,507,922	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)		9,849,968		11,507,922	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		561,691		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		3,724	6.02
7.00	Total Medicare program liability (see instructions)		10,411,659		11,504,198	7.00

			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-0057	Period: From 01/01/2023 To 12/31/2023	Worksheet E-1 Part II Date/Time Prepared: 5/31/2024 10:46 am
	Title XVIII	Hospital	PPS

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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0057	Period: From 01/01/2023 To 12/31/2023	Worksheet E-3 Part VII Date/Time Prepared: 5/31/2024 10:46 am
	Title XIX	Hospital	PPS

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	0		1.00
2.00	Medical and other services		8,525,421	2.00
3.00	Organ acquisition (certified transplant programs only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	0	8,525,421	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)	0	8,525,421	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	0		8.00
9.00	Ancillary service charges	13,617,893	79,373,668	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)	13,617,893	79,373,668	12.00
	CUSTOMARY CHARGES			
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	13,617,893	79,373,668	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	13,617,893	70,848,247	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)	0	8,525,421	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	0	8,525,421	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	0	8,525,421	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	0	8,525,421	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	0	8,525,421	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)	0	8,525,421	40.00
41.00	Interim payments	0	8,525,421	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

OUTLIER RECONCILIATION AT TENTATIVE SETTLEMENT	Provider CCN: 15-0057	Period: From 01/01/2023 To 12/31/2023	Worksheet E-5 Date/Time Prepared: 5/31/2024 10:46 am
	Title XVIII		PPS

		1.00	
	TO BE COMPLETED BY CONTRACTOR		
1.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)	0	1.00
2.00	Capital outlier from Wkst. L, Pt. I, line 2	0	2.00
3.00	Operating outlier reconciliation adjustment amount (see instructions)	0	3.00
4.00	Capital outlier reconciliation adjustment amount (see instructions)	0	4.00
5.00	The rate used to calculate the time value of money (see instructions)	0.00	5.00
6.00	Time value of money for operating expenses (see instructions)	0	6.00
7.00	Time value of money for capital related expenses (see instructions)	0	7.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 15-0057 | Period: From 01/01/2023 To 12/31/2023 | Worksheet G | Date/Time Prepared: 5/31/2024 10:46 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	57,286,616	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	82,115,141	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-63,539,928	0	0	0	6.00
7.00	Inventory	2,632,829	0	0	0	7.00
8.00	Prepaid expenses	459,321	0	0	0	8.00
9.00	Other current assets	601,889	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)	79,555,868	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	922,177	0	0	0	12.00
13.00	Land improvements	4,557,095	0	0	0	13.00
14.00	Accumulated depreciation	-395,665	0	0	0	14.00
15.00	Buildings	76,279,911	0	0	0	15.00
16.00	Accumulated depreciation	-75,143,569	0	0	0	16.00
17.00	Leasehold improvements	15,703,133	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	54,143,820	0	0	0	19.00
20.00	Accumulated depreciation	-6,952,486	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	34,213,890	0	0	0	23.00
24.00	Accumulated depreciation	931,386	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	104,259,692	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	3,887,077	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	3,887,077	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	187,702,637	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	11,493,331	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,828,234	0	0	0	38.00
39.00	Payroll taxes payable	327,511	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	2,571,043	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	16,220,119	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	111,918	0	0	0	48.00
49.00	Other long term liabilities	968,256	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	1,080,174	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	17,300,293	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	170,402,344				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)	170,402,344	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	187,702,637	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-0057 | Period: From 01/01/2023 To 12/31/2023 | Worksheet G-1 | Date/Time Prepared: 5/31/2024 10:46 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		127,431,026		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		42,971,310				2.00
3.00	Total (sum of line 1 and line 2)		170,402,336		0		3.00
4.00	ROUNDING	8		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		8		0		10.00
11.00	Subtotal (line 3 plus line 10)		170,402,344		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		170,402,344		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	ROUNDING		0			4.00
5.00			0			5.00
6.00			0			6.00
7.00			0			7.00
8.00			0			8.00
9.00			0			9.00
10.00	Total additions (sum of line 4-9)	0		0		10.00
11.00	Subtotal (line 3 plus line 10)	0		0		11.00
12.00	Deductions (debit adjustments) (specify)		0			12.00
13.00			0			13.00
14.00			0			14.00
15.00			0			15.00
16.00			0			16.00
17.00			0			17.00
18.00	Total deductions (sum of lines 12-17)	0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0		19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 15-0057 | Period: From 01/01/2023 To 12/31/2023 | Worksheet G-2 Parts I & II Date/Time Prepared: 5/31/2024 10:46 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	19,394,421		19,394,421	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	19,394,421		19,394,421	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT	5,684,805		5,684,805	14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	5,684,805		5,684,805	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	25,079,226		25,079,226	17.00
18.00	Ancillary services	92,494,008	393,073,110	485,567,118	18.00
19.00	Outpatient services	13,706,702	112,756,846	126,463,548	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	NRCC	40,935	37,903,089	37,944,024	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	131,320,871	543,733,045	675,053,916	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		110,597,005		29.00
30.00	TRANSFER TO RHO AND INDIANAPOLIS	5,639,800			30.00
31.00	TRANSFER FROM INDIANPOLIS	2,468,681			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)		8,108,481		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)		118,705,486		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 15-0057 | Period: From 01/01/2023 To 12/31/2023 | Worksheet G-3 | Date/Time Prepared: 5/31/2024 10:46 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	675,053,916	1.00
2.00	Less contractual allowances and discounts on patients' accounts	522,784,144	2.00
3.00	Net patient revenues (line 1 minus line 2)	152,269,772	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	118,705,486	4.00
5.00	Net income from service to patients (line 3 minus line 4)	33,564,286	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	544	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	501,435	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	321,989	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	931	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	146,446	20.00
21.00	Rental of vending machines	10,136	21.00
22.00	Rental of hospital space	2,098,713	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER OPERATING REVENUE	6,326,830	24.00
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (sum of lines 6-24)	9,407,024	25.00
26.00	Total (line 5 plus line 25)	42,971,310	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)	42,971,310	29.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 15-0057	Period: From 01/01/2023 To 12/31/2023	Worksheet L Parts I-III Date/Time Prepared: 5/31/2024 10:46 am
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	589,416	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	3,836	2.00
2.01	Model 4 BPCI Capital DRG outlier payments	0	2.01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)	20.01	3.00
4.00	Number of interns & residents (see instructions)	0.00	4.00
5.00	Indirect medical education percentage (see instructions)	0.00	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)	0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)	0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	0.00	8.00
9.00	Sum of lines 7 and 8	0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)	0.00	10.00
11.00	Disproportionate share adjustment (see instructions)	0	11.00
12.00	Total prospective capital payments (see instructions)	593,252	12.00
		1.00	
	PART II - PAYMENT UNDER REASONABLE COST		
1.00	Program inpatient routine capital cost (see instructions)	0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)	0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)	0	3.00
4.00	Capital cost payment factor (see instructions)	0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)	0	5.00
		1.00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS		
1.00	Program inpatient capital costs (see instructions)	0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)	0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)	0	3.00
4.00	Applicable exception percentage (see instructions)	0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)	0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)	0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)	0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)	0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)	0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)	0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)	0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)	0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)	0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)	0	14.00
15.00	Current year allowable operating and capital payment (see instructions)	0	15.00
16.00	Current year operating and capital costs (see instructions)	0	16.00
17.00	Current year exception offset amount (see instructions)	0	17.00