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: 15-1328	Period: From 01/01/2023 To 12/31/2023	Worksheet S Parts I-III Date/Time Prepared: 5/29/2024 2:18 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 5/29/2024 Time: 2:18 pm
2. [ ] Manually prepared cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no.

Contractor use only

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

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

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by INDIANA UNIVERSITY HEALTH BEDFORD (15-1328) 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	Michael Craig		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	Michael Craig			2
3	Signatory Title	CHIEF FINANCIAL OFFICER			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	-782,379	119,580	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	-782,379	119,580	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: 15-1328 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I | Date/Time Prepared: 5/29/2024 2:18 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 2900 WEST SIXTEENTH STREET	PO Box:			1.00
2.00	City: BEDFORD	State: IN	Zip Code: 47421-	County: LAWRENCE	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	INDIANA UNIVERSITY HEALTH BEDFORD	151328	99915	1	10/01/2005	N	O	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	IU HEALTH BEDFORD - SWING BED	15Z328	99915		10/01/2005	N	O	O	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.	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)	N	N		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: 15-1328 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I Date/Time Prepared: 5/29/2024 2:18 pm

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

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

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

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

		V	XVIII	XIX	
		1.00	2.00	3.00	
	Prospective Payment System (PPS)-Capital				
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	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			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.				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

		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)				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

		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

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

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-1328	Period: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part I Date/Time Prepared: 5/29/2024 2:18 pm

		V	XIX	
		1.00	2.00	
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.06
	Rural Providers			
105.00	Does this hospital qualify as a CAH?	Y		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.	1			118.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-1328	Period: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part I Date/Time Prepared: 5/29/2024 2:18 pm

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	54,446	0	0	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	Y	5.00	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	N	123.00
	Certified Transplant Center Information			
125.00	Does this facility operate a Medicare-certified transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare-certified kidney transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare-certified heart transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare-certified liver transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare-certified lung transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare-certified pancreas transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare-certified intestinal transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare-certified islet transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	Removed and reserved			133.00
134.00	If this is a hospital-based organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	15H059	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: INDIANA UNIVERSITY HEALTH, INC	Contractor's Name: WPS	Contractor's Number: 08101	141.00
142.00	Street: 340 WEST 10TH STREET	PO Box:		142.00
143.00	City: INDIANAPOLIS	State: IN	Zip Code: 46202	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

		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)	0.00	169.00

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			170.00
		1.00	2.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)	Y	269	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-1328 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part II Date/Time Prepared: 5/29/2024 2:18 pm

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

		Y/N	Date	
		1.00	2.00	
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

Financial Data and Reports

		Y/N	Type	Date	
		1.00	2.00	3.00	
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	02/22/2024	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

Approved Educational Activities

		Y/N	Legal Oper.	
		1.00	2.00	
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

Bad Debts

		Y/N	
		1.00	
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

PS&R Data

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
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	04/01/2024	Y	04/01/2024	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

		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.	N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.	N		40.00

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	RHONDA	UTTER	41.00
42.00	Enter the employer/company name of the cost report preparer.	INDIANA UNIVERSITY HEALTH		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-556-3910	RUTTER@IUHEALTH.ORG	43.00

		3.00		
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	DIRECTOR		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: 15-1328 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part I Date/Time Prepared: 5/29/2024 2:18 pm

	Component	Worksheet A Line No.	No. of Beds	Bed Days Available	CAH/REH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	19	6,935	126,000.00	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)		19	6,935	126,000.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	6	2,190	35,640.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		25	9,125	161,640.00	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)		25				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: 15-1328 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part I | Date/Time Prepared: 5/29/2024 2:18 pm

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	2,162	111	5,250			1.00
2.00	HMO and other (see instructions)	2,278	634				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)	2,162	111	5,250			7.00
8.00	INTENSIVE CARE UNIT	562	37	1,485			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)	2,724	148	6,735	0.00	260.19	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)			110			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	260.19	27.00
28.00	Observation Bed Days		15	1,377			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	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care	0	0	0			34.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA	Provider CCN: 15-1328	Period: From 01/01/2023 To 12/31/2023	Worksheet S-3 Part I Date/Time Prepared: 5/29/2024 2:18 pm

	Component	Full Time Equivalents Nonpaid Workers	Discharges 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	690	35	1,631	1.00
2.00	HMO and other (see instructions)			508	159		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	690	35	1,631	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 UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-1328 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-10 Parts I & II Date/Time Prepared: 5/29/2024 2:18 pm

		1.00	
	PART I - HOSPITAL AND HOSPITAL COMPLEX DATA		
	Uncompensated and Indigent Care Cost-to-Charge Ratio		
1.00	Cost to charge ratio (see instructions)	0.213430	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	13,591,119	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	N	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	60,778,798	6.00
7.00	Medicaid cost (line 1 times line 6)	12,972,019	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)	4,620,552	338,786	4,959,338	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	986,164	240,407	1,226,571	21.00
22.00	Payments received from patients for amounts previously written off as charity care	3,520	0	3,520	22.00
23.00	Cost of charity care (see instructions)	982,644	240,407	1,223,051	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)	125,074	25.01
26.00	Bad debt amount (see instructions)	5,711,914	26.00
27.00	Medicare reimbursable bad debts (see instructions)	865,339	27.00
27.01	Medicare allowable bad debts (see instructions)	1,331,291	27.01
28.00	Non-Medicare bad debt amount (see instructions)	4,380,623	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)	1,400,908	29.00
30.00	Cost of uncompensated care (line 23, col. 3, plus line 29)	2,623,959	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	2,623,959	31.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-1328 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-10 Parts I & II Date/Time Prepared: 5/29/2024 2:18 pm

		1.00	
	PART II - HOSPITAL DATA		
	Uncompensated and Indigent Care Cost-to-Charge Ratio		
1.00	Cost to charge ratio (see instructions)		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)				20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)				21.00
22.00	Payments received from patients for amounts previously written off as charity care				22.00
23.00	Cost of charity care (see instructions)				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?		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		25.00
25.01	Charges for insured patients' liability (see instructions)		25.01
26.00	Bad debt amount (see instructions)		26.00
27.00	Medicare reimbursable bad debts (see instructions)		27.00
27.01	Medicare allowable bad debts (see instructions)		27.01
28.00	Non-Medicare bad debt amount (see instructions)		28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)		29.00
30.00	Cost of uncompensated care (line 23, col. 3, plus line 29)		30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1328 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A | Date/Time Prepared: 5/29/2024 2:18 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		0	0	549,267	549,267	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	1,689,582	1,689,582	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	8,008	8,008	3,833,964	3,841,972	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	667,435	19,139,409	19,806,844	-470,290	19,336,554	5.00
7.00	00700	OPERATION OF PLANT	736,364	4,286,498	5,022,862	-1,201,963	3,820,899	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	172,672	172,672	0	172,672	8.00
9.00	00900	HOUSEKEEPING	533,445	563,599	1,097,044	-143,320	953,724	9.00
10.00	01000	DIETARY	430,792	546,124	976,916	-447,396	529,520	10.00
11.00	01100	CAFETERIA	0	0	0	300,704	300,704	11.00
13.00	01300	NURSING ADMINISTRATION	1,810,430	855,412	2,665,842	-585,266	2,080,576	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	101,154	149,587	250,741	519,931	770,672	14.00
15.00	01500	PHARMACY	875,782	15,227,402	16,103,184	-14,343,785	1,759,399	15.00
17.00	01700	SOCIAL SERVICE	0	0	0	49,702	49,702	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,896,660	3,853,753	6,750,413	-647,390	6,103,023	30.00
31.00	03100	INTENSIVE CARE UNIT	1,698,411	1,229,132	2,927,543	-427,356	2,500,187	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	995,994	3,307,408	4,303,402	-1,130,777	3,172,625	50.00
51.00	05100	RECOVERY ROOM	382,722	121,589	504,311	-88,048	416,263	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,277,325	764,358	2,041,683	-107,651	1,934,032	54.00
56.00	05600	RADIOISOTOPE	93,287	203,696	296,983	-59,899	237,084	56.00
57.00	05700	CT SCAN	515,308	555,160	1,070,468	-508,071	562,397	57.00
58.00	05800	MRI	273,767	140,152	413,919	-33,191	380,728	58.00
60.00	06000	LABORATORY	322,883	4,680,784	5,003,667	-27,989	4,975,678	60.00
65.00	06500	RESPIRATORY THERAPY	947,227	454,391	1,401,618	-253,855	1,147,763	65.00
66.00	06600	PHYSICAL THERAPY	766,975	346,903	1,113,878	-145,181	968,697	66.00
67.00	06700	OCCUPATIONAL THERAPY	311,963	78,590	390,553	-54,861	335,692	67.00
68.00	06800	SPEECH PATHOLOGY	180,191	51,074	231,265	-37,265	194,000	68.00
69.00	06900	ELECTROCARDIOLOGY	466,318	839,493	1,305,811	-277,423	1,028,388	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	368,358	368,358	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	186,254	186,254	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	14,742,704	14,742,704	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	85,185	85,185	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,158,606	567,361	1,725,967	-342,012	1,383,955	90.00
90.01	09001	CLINIC - DIABETES	0	583	583	-150	433	90.01
91.00	09100	EMERGENCY	3,474,686	4,108,345	7,583,031	-1,039,161	6,543,870	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	20,917,725	62,251,483	83,169,208	-46,649	83,122,559	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	17,301	17,881	35,182	-16,573	18,609	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	3	3	63,298	63,301	192.00
194.00	07950	OCCUPATIONAL HEALTH	0	5,556	5,556	-76	5,480	194.00
194.02	07952	BLOOMNGTN AMBULANCE AND OCC MED	0	0	0	0	0	194.02
194.03	07953	HOME CARE	0	0	0	0	0	194.03
200.00		TOTAL (SUM OF LINES 118 through 199)	20,935,026	62,274,923	83,209,949	0	83,209,949	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1328 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A | Date/Time Prepared: 5/29/2024 2:18 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
	GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	249,484	798,751	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	274,510	1,964,092	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-164,422	3,677,550	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-3,498,997	15,837,557	5.00
7.00	00700	OPERATION OF PLANT	-13,434	3,807,465	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	-901	171,771	8.00
9.00	00900	HOUSEKEEPING	-688	953,036	9.00
10.00	01000	DIETARY	0	529,520	10.00
11.00	01100	CAFETERIA	0	300,704	11.00
13.00	01300	NURSING ADMINISTRATION	156,035	2,236,611	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	770,672	14.00
15.00	01500	PHARMACY	113,741	1,873,140	15.00
17.00	01700	SOCIAL SERVICE	0	49,702	17.00
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-1,652,009	4,451,014	30.00
31.00	03100	INTENSIVE CARE UNIT	-413,106	2,087,081	31.00
	ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-1,375,628	1,796,997	50.00
51.00	05100	RECOVERY ROOM	0	416,263	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	55,732	1,989,764	54.00
56.00	05600	RADIOISOTOPE	0	237,084	56.00
57.00	05700	CT SCAN	0	562,397	57.00
58.00	05800	MRI	0	380,728	58.00
60.00	06000	LABORATORY	-314,608	4,661,070	60.00
65.00	06500	RESPIRATORY THERAPY	-59,410	1,088,353	65.00
66.00	06600	PHYSICAL THERAPY	118,692	1,087,389	66.00
67.00	06700	OCCUPATIONAL THERAPY	-3,273	332,419	67.00
68.00	06800	SPEECH PATHOLOGY	0	194,000	68.00
69.00	06900	ELECTROCARDIOLOGY	-11,125	1,017,263	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	368,358	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	186,254	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	14,742,704	73.00
76.97	07697	CARDIAC REHABILITATION	0	85,185	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	78.00
	OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	-4,408	1,379,547	90.00
90.01	09001	CLINIC - DIABETES	-433	0	90.01
91.00	09100	EMERGENCY	2,734,674	9,278,544	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
	OTHER REIMBURSABLE COST CENTERS				
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	102.00
	SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-3,809,574	79,312,985	118.00
	NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	18,609	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	63,301	192.00
194.00	07950	OCCUPATIONAL HEALTH	0	5,480	194.00
194.02	07952	BLOOMNGTN AMBULANCE AND OCC MED	0	0	194.02
194.03	07953	HOME CARE	0	0	194.03
200.00		TOTAL (SUM OF LINES 118 through 199)	-3,809,574	79,400,375	200.00

RECLASSIFICATIONS | Provider CCN: 15-1328 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-6

Date/Time Prepared: 5/29/2024 2:18 pm

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - BENEFITS				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	3,833,154	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
	0		0	3,833,154	
	B - DIETARY/CAFETERIA				
1.00	CAFETERIA	11.00	149,471	151,233	1.00
	0		149,471	151,233	
	C - CAPITAL LEASE				
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	63,283	1.00
	0		0	63,283	
	D - CARDIOLOGY				
1.00	CARDIAC REHABILITATION	76.97	75,090	10,095	1.00
	0		75,090	10,095	
	E - DEPR EXPENSE				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	477,593	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	1,670,308	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
	0		0	2,147,901	
	F - BILLABLE DRUGS				
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	14,742,704	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
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
	0		0	14,742,704	
	G - IMPLANT SUPPLIES				
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	186,254	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
	0		0	186,254	
	I - BILLABLE MEDICAL SUPPLIES				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	368,358	1.00
2.00	RESPIRATORY THERAPY	65.00	0	51	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
	0		0	368,409	
	J - PROPERTY INSURANCE				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	71,908	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	19,274	2.00
	0		0	91,182	
	K - PROPERTY TAXES				
1.00	ADMINISTRATIVE & GENERAL	5.00	0	234	1.00
	0		0	234	
	L - SOCIAL WORKER				
1.00	SOCIAL SERVICE	17.00	49,702	0	1.00
	0		49,702	0	
	M - NONBILLABLE DRUGS				
1.00	PHARMACY	15.00	0	308,252	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
	0		0	308,252	
	N - NONBILLABLE MEDICAL SUPPLIES				
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	623,382	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	2,205	2.00
3.00	OPERATION OF PLANT	7.00	0	12,251	3.00
4.00	HOUSEKEEPING	9.00	0	204	4.00
5.00	DIETARY	10.00	0	53	5.00
6.00	RADIOISOTOPE	56.00	0	1,942	6.00
7.00	CT SCAN	57.00	0	6,272	7.00
8.00	PHYSICAL THERAPY	66.00	0	788	8.00
9.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	15	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	647,112	

RECLASSIFICATIONS | Provider CCN: 15-1328 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-6 | Date/Time Prepared: 5/29/2024 2:18 pm

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	P - COMMUNITY BENEFIT				
1.00	OCCUPATIONAL HEALTH	194.00	0	1,092	1.00
	0		0	1,092	
	R - TRIMEDX				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	836	1.00
2.00	OPERATION OF PLANT	7.00	0	1,868	2.00
3.00	CENTRAL SERVICES & SUPPLY	14.00	0	46,238	3.00
4.00	PHARMACY	15.00	0	1,742	4.00
5.00	ADULTS & PEDIATRICS	30.00	0	60,764	5.00
6.00	INTENSIVE CARE UNIT	31.00	0	14,024	6.00
7.00	OPERATING ROOM	50.00	0	68,289	7.00
8.00	RECOVERY ROOM	51.00	0	685	8.00
9.00	RADIOLOGY-DIAGNOSTIC	54.00	0	442,042	9.00
10.00	RADIOISOTOPE	56.00	0	310	10.00
11.00	MRI	58.00	0	81,564	11.00
12.00	LABORATORY	60.00	0	583	12.00
13.00	RESPIRATORY THERAPY	65.00	0	14,285	13.00
14.00	PHYSICAL THERAPY	66.00	0	3,468	14.00
15.00	ELECTROCARDIOLOGY	69.00	0	30,233	15.00
16.00	CLINIC	90.00	0	2,486	16.00
17.00	EMERGENCY	91.00	0	14,306	17.00
18.00	OCCUPATIONAL HEALTH	194.00	0	4,386	18.00
	TOTALS		0	788,109	
500.00	Grand Total: Increases		274,263	23,339,014	500.00

RECLASSIFICATIONS | Provider CCN: 15-1328 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-6 | Date/Time Prepared: 5/29/2024 2:18 pm

	Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
	A - BENEFITS					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	91,967	0	1.00
2.00	OPERATION OF PLANT	7.00	0	189,885	0	2.00
3.00	HOUSEKEEPING	9.00	0	121,213	0	3.00
4.00	DIETARY	10.00	0	129,978	0	4.00
5.00	NURSING ADMINISTRATION	13.00	0	289,977	0	5.00
6.00	CENTRAL SERVICES & SUPPLY	14.00	0	55,756	0	6.00
7.00	PHARMACY	15.00	0	157,292	0	7.00
8.00	ADULTS & PEDIATRICS	30.00	0	470,747	0	8.00
9.00	INTENSIVE CARE UNIT	31.00	0	317,483	0	9.00
10.00	OPERATING ROOM	50.00	0	202,864	0	10.00
11.00	RECOVERY ROOM	51.00	0	72,084	0	11.00
12.00	RADIOLOGY-DIAGNOSTIC	54.00	0	212,803	0	12.00
13.00	RADIOISOTOPE	56.00	0	31,605	0	13.00
14.00	CT SCAN	57.00	0	76,011	0	14.00
15.00	MRI	58.00	0	56,027	0	15.00
16.00	LABORATORY	60.00	0	28,572	0	16.00
17.00	RESPIRATORY THERAPY	65.00	0	158,559	0	17.00
18.00	PHYSICAL THERAPY	66.00	0	143,969	0	18.00
19.00	OCCUPATIONAL THERAPY	67.00	0	54,861	0	19.00
20.00	SPEECH PATHOLOGY	68.00	0	36,681	0	20.00
21.00	ELECTROCARDIOLOGY	69.00	0	50,493	0	21.00
22.00	CLINIC	90.00	0	239,251	0	22.00
23.00	EMERGENCY	91.00	0	628,503	0	23.00
24.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00	0	16,573	0	24.00
	0		0	3,833,154		
	B - DIETARY/CAFETERIA					
1.00	DIETARY	10.00	149,471	151,233	0	1.00
	0		149,471	151,233		
	C - CAPITAL LEASE					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	63,283	0	1.00
	0		0	63,283		
	D - CARDIOLOGY					
1.00	ELECTROCARDIOLOGY	69.00	75,090	10,095	0	1.00
	0		75,090	10,095		
	E - DEPR EXPENSE					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	26	9	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	220,316	9	2.00
3.00	OPERATION OF PLANT	7.00	0	238,088	0	3.00
4.00	HOUSEKEEPING	9.00	0	22,299	0	4.00
5.00	DIETARY	10.00	0	16,761	0	5.00
6.00	NURSING ADMINISTRATION	13.00	0	243,192	0	6.00
7.00	CENTRAL SERVICES & SUPPLY	14.00	0	72,355	0	7.00
8.00	PHARMACY	15.00	0	69,399	0	8.00
9.00	ADULTS & PEDIATRICS	30.00	0	58,365	0	9.00
10.00	INTENSIVE CARE UNIT	31.00	0	58,244	0	10.00
11.00	OPERATING ROOM	50.00	0	282,195	0	11.00
12.00	RECOVERY ROOM	51.00	0	14,678	0	12.00
13.00	RADIOLOGY-DIAGNOSTIC	54.00	0	272,202	0	13.00
14.00	RADIOISOTOPE	56.00	0	29,477	0	14.00
15.00	CT SCAN	57.00	0	292,141	0	15.00
16.00	MRI	58.00	0	35,850	0	16.00
17.00	RESPIRATORY THERAPY	65.00	0	44,515	0	17.00
18.00	PHYSICAL THERAPY	66.00	0	3,994	0	18.00
19.00	SPEECH PATHOLOGY	68.00	0	584	0	19.00
20.00	ELECTROCARDIOLOGY	69.00	0	96,322	0	20.00
21.00	CLINIC	90.00	0	6,414	0	21.00
22.00	CLINIC - DIABETES	90.01	0	150	0	22.00
23.00	EMERGENCY	91.00	0	70,334	0	23.00
	0		0	2,147,901		
	F - BILLABLE DRUGS					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	4,889	0	1.00
2.00	NURSING ADMINISTRATION	13.00	0	560	0	2.00
3.00	CENTRAL SERVICES & SUPPLY	14.00	0	2,658	0	3.00
4.00	PHARMACY	15.00	0	14,416,047	0	4.00
5.00	ADULTS & PEDIATRICS	30.00	0	21,050	0	5.00
6.00	INTENSIVE CARE UNIT	31.00	0	7,783	0	6.00
7.00	OPERATING ROOM	50.00	0	19,615	0	7.00
8.00	RADIOLOGY-DIAGNOSTIC	54.00	0	13,198	0	8.00
9.00	RADIOISOTOPE	56.00	0	381	0	9.00
10.00	CT SCAN	57.00	0	142,934	0	10.00
11.00	MRI	58.00	0	22,134	0	11.00
12.00	RESPIRATORY THERAPY	65.00	0	1,080	0	12.00

	Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
13.00	PHYSICAL THERAPY	66.00	0	62	0	13.00
14.00	ELECTROCARDIOLOGY	69.00	0	53,459	0	14.00
15.00	CLINIC	90.00	0	2,563	0	15.00
16.00	EMERGENCY	91.00	0	28,737	0	16.00
17.00	OCCUPATIONAL HEALTH	194.00	0	5,554	0	17.00
	0		0	14,742,704		
	G - IMPLANT SUPPLIES					
1.00	NURSING ADMINISTRATION	13.00	0	26	0	1.00
2.00	CENTRAL SERVICES & SUPPLY	14.00	0	2,355	0	2.00
3.00	PHARMACY	15.00	0	174	0	3.00
4.00	ADULTS & PEDIATRICS	30.00	0	419	0	4.00
5.00	INTENSIVE CARE UNIT	31.00	0	170	0	5.00
6.00	OPERATING ROOM	50.00	0	145,985	0	6.00
7.00	CLINIC	90.00	0	34,453	0	7.00
8.00	EMERGENCY	91.00	0	2,672	0	8.00
	0		0	186,254		
	I - BILLABLE MEDICAL SUPPLIES					
1.00	HOUSEKEEPING	9.00	0	12	0	1.00
2.00	DIETARY	10.00	0	6	0	2.00
3.00	CENTRAL SERVICES & SUPPLY	14.00	0	14,796	0	3.00
4.00	ADULTS & PEDIATRICS	30.00	0	17,596	0	4.00
5.00	INTENSIVE CARE UNIT	31.00	0	7,792	0	5.00
6.00	OPERATING ROOM	50.00	0	272,468	0	6.00
7.00	RADIOLOGY-DIAGNOSTIC	54.00	0	2,864	0	7.00
8.00	RADIOISOTOPE	56.00	0	73	0	8.00
9.00	CT SCAN	57.00	0	32	0	9.00
10.00	MRI	58.00	0	10	0	10.00
11.00	PHYSICAL THERAPY	66.00	0	1,412	0	11.00
12.00	ELECTROCARDIOLOGY	69.00	0	207	0	12.00
13.00	CLINIC	90.00	0	13,307	0	13.00
14.00	EMERGENCY	91.00	0	37,834	0	14.00
	0		0	368,409		
	J - PROPERTY INSURANCE					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	91,182	12	1.00
2.00		0.00	0	0	12	2.00
	0		0	91,182		
	K - PROPERTY TAXES					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	234	13	1.00
	0		0	234		
	L - SOCIAL WORKER					
1.00	NURSING ADMINISTRATION	13.00	49,702	0	0	1.00
	0		49,702	0		
	M - NONBILLABLE DRUGS					
1.00	NURSING ADMINISTRATION	13.00	0	1,206	0	1.00
2.00	CENTRAL SERVICES & SUPPLY	14.00	0	1,312	0	2.00
3.00	ADULTS & PEDIATRICS	30.00	0	39,461	0	3.00
4.00	INTENSIVE CARE UNIT	31.00	0	19,529	0	4.00
5.00	OPERATING ROOM	50.00	0	35,188	0	5.00
6.00	RECOVERY ROOM	51.00	0	601	0	6.00
7.00	RADIOLOGY-DIAGNOSTIC	54.00	0	14,448	0	7.00
8.00	RADIOISOTOPE	56.00	0	615	0	8.00
9.00	CT SCAN	57.00	0	3,225	0	9.00
10.00	MRI	58.00	0	312	0	10.00
11.00	ELECTROCARDIOLOGY	69.00	0	2,101	0	11.00
12.00	CLINIC	90.00	0	35,374	0	12.00
13.00	EMERGENCY	91.00	0	154,880	0	13.00
	0		0	308,252		
	N - NONBILLABLE MEDICAL SUPPLIES					
1.00	NURSING ADMINISTRATION	13.00	0	603	0	1.00
2.00	CENTRAL SERVICES & SUPPLY	14.00	0	457	0	2.00
3.00	PHARMACY	15.00	0	10,867	0	3.00
4.00	ADULTS & PEDIATRICS	30.00	0	100,516	0	4.00
5.00	INTENSIVE CARE UNIT	31.00	0	30,379	0	5.00
6.00	OPERATING ROOM	50.00	0	240,751	0	6.00
7.00	RECOVERY ROOM	51.00	0	1,370	0	7.00
8.00	RADIOLOGY-DIAGNOSTIC	54.00	0	34,178	0	8.00
9.00	MRI	58.00	0	422	0	9.00
10.00	RESPIRATORY THERAPY	65.00	0	64,037	0	10.00
11.00	ELECTROCARDIOLOGY	69.00	0	19,889	0	11.00
12.00	CLINIC	90.00	0	13,136	0	12.00
13.00	EMERGENCY	91.00	0	130,507	0	13.00
	0		0	647,112		

	Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
	P - COMMUNITY BENEFIT					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	1,092	0	1.00
	0		0	1,092		
	R - TRIMEDX					
1.00	OPERATION OF PLANT	7.00	0	788,109	0	1.00
2.00		0.00	0	0	0	2.00
3.00		0.00	0	0	0	3.00
4.00		0.00	0	0	0	4.00
5.00		0.00	0	0	0	5.00
6.00		0.00	0	0	0	6.00
7.00		0.00	0	0	0	7.00
8.00		0.00	0	0	0	8.00
9.00		0.00	0	0	0	9.00
10.00		0.00	0	0	0	10.00
11.00		0.00	0	0	0	11.00
12.00		0.00	0	0	0	12.00
13.00		0.00	0	0	0	13.00
14.00		0.00	0	0	0	14.00
15.00		0.00	0	0	0	15.00
16.00		0.00	0	0	0	16.00
17.00		0.00	0	0	0	17.00
18.00		0.00	0	0	0	18.00
	TOTALS		0	788,109		
500.00	Grand Total: Decreases		274,263	23,339,014		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1328 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-7 Part I | Date/Time Prepared: 5/29/2024 2:18 pm

		Beginning Balances	Acquisitions Purchases	Acquisitions Donation	Acquisitions Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	1,034,321	0	0	0	0	1.00
2.00	Land Improvements	1,093,347	0	0	0	0	2.00
3.00	Buildings and Fixtures	13,907,417	0	0	0	0	3.00
4.00	Building Improvements	6,211,197	546,183	0	546,183	3,932	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	19,388,690	2,510,844	0	2,510,844	638,041	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	41,634,972	3,057,027	0	3,057,027	641,973	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	41,634,972	3,057,027	0	3,057,027	641,973	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	1,034,321	0	1.00
2.00	Land Improvements	1,093,347	0	2.00
3.00	Buildings and Fixtures	13,907,417	0	3.00
4.00	Building Improvements	6,753,448	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	21,261,493	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	44,050,026	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	44,050,026	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1328 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-7 Part II | Date/Time Prepared: 5/29/2024 2:18 pm

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

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

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-1328 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-7 Part III | Date/Time Prepared: 5/29/2024 2:18 pm

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	22,788,532	0	22,788,532	0.517333	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	21,261,493	0	21,261,493	0.482667	0	2.00
3.00	Total (sum of lines 1-2)	44,050,025	0	44,050,025	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	477,593	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	1,944,818	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	2,422,411	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	249,484	71,908	-234	0	798,751	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	19,274	0	0	1,964,092	2.00
3.00	Total (sum of lines 1-2)	249,484	91,182	-234	0	2,762,843	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1328 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-8 | Date/Time Prepared: 5/29/2024 2:18 pm

				Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
	Cost Center Description	Basis/Code (2)	Amount	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)	B	-6,494,981	CAP REL COSTS-BLDG & FIXT	1.00	11	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)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-3,801,544			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	16,470,136			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	0	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	A	0	CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00
33.00	MISCELLANEOUS INCOME	B	-74,406	ADMINISTRATIVE & GENERAL	5.00	0	33.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1328 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-8 | Date/Time Prepared: 5/29/2024 2:18 pm

				Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
34.00	MISCELLANEOUS INCOME	B	-113,671	OPERATION OF PLANT	7.00	0	34.00
35.00	MISCELLANEOUS INCOME	B	-901	LAUNDRY & LINEN SERVICE	8.00	0	35.00
36.00	MISCELLANEOUS INCOME	B	-688	HOUSEKEEPING	9.00	0	36.00
37.00	MISCELLANEOUS INCOME	B	-68	PHARMACY	15.00	0	37.00
38.00	MISCELLANEOUS INCOME	B	-231	ADULTS & PEDIATRICS	30.00	0	38.00
39.00	MISCELLANEOUS INCOME	B	-5,000	RADIOLOGY-DIAGNOSTIC	54.00	0	39.00
45.00	MISCELLANEOUS INCOME	B	-82,290	RESPIRATORY THERAPY	65.00	0	45.00
45.01	MISCELLANEOUS INCOME	B	-3,273	OCCUPATIONAL THERAPY	67.00	0	45.01
45.02	MISCELLANEOUS INCOME	B	-11,125	ELECTROCARDIOLOGY	69.00	9	45.02
45.03	UNWONTED SITUATIONS	A	-250	ADULTS & PEDIATRICS	30.00	0	45.03
45.04	INVESTMENT FEES	B	6,914	ADMINISTRATIVE & GENERAL	5.00	0	45.04
45.05	PHONES	A	-2,690	CAP REL COSTS-MVBLE EQUIP	2.00	9	45.05
45.06	HAF	A	-5,844,285	ADMINISTRATIVE & GENERAL	5.00	0	45.06
45.07	MARKETING	A	-9,569	ADMINISTRATIVE & GENERAL	5.00	0	45.07
45.08	MARKETING	A	-57	CLINIC	90.00	0	45.08
45.09	BENEFITS	A	-3,833,154	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	45.09
45.10	CONTRIBUTION EXPENSE	A	-7,880	ADMINISTRATIVE & GENERAL	5.00	0	45.10
45.11	CONTRIBUTION EXPENSE	A	-128	RADIOLOGY-DIAGNOSTIC	54.00	0	45.11
45.12	DIABETES CLINIC	A	-433	CLINIC - DIABETES	90.01	0	45.12
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-3,809,574				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: 15-1328 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-8-1 | Date/Time Prepared: 5/29/2024 2:18 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	1.00	CAP REL COSTS-BLDG & FIXT	HOME OFFICE	6,744,465	0	1.00
2.00	2.00	CAP REL COSTS-MVBLE EQUIP	HOME OFFICE	277,200	0	2.00
3.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE	3,654,009	0	3.00
4.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE	11,609,329	10,493,580	4.00
4.01	4.00	EMPLOYEE BENEFITS DEPARTMENT	RELATED PARTY	14,723	0	4.01
4.02	5.00	ADMINISTRATIVE & GENERAL	RELATED PARTY	2,386,885	1,072,405	4.02
4.03	7.00	OPERATION OF PLANT	RELATED PARTY	100,237	0	4.03
4.05	13.00	NURSING ADMINISTRATION	RELATED PARTY	226,256	70,221	4.05
4.06	15.00	PHARMACY	RELATED PARTY	562,192	448,383	4.06
4.07	54.00	RADIOLOGY-DIAGNOSTIC	RELATED PARTY	103,183	0	4.07
4.08	65.00	RESPIRATORY THERAPY	RELATED PARTY	22,880	0	4.08
4.09	66.00	PHYSICAL THERAPY	RELATED PARTY	229,460	110,768	4.09
4.10	91.00	EMERGENCY	EMERGENCY ROOM	3,545,523	810,849	4.10
4.11	4.00	EMPLOYEE BENEFITS DEPARTMENT	SHARED EMPLOYEES	1,790	1,790	4.11
4.12	5.00	ADMINISTRATIVE & GENERAL	SHARED EMPLOYEES	7,680	7,680	4.12
4.13	10.00	DIETARY	SHARED EMPLOYEES	36,178	36,178	4.13
4.14	30.00	ADULTS & PEDIATRICS	SHARED EMPLOYEES	1,745,246	1,745,246	4.14
4.15	31.00	INTENSIVE CARE UNIT	SHARED EMPLOYEES	413,106	413,106	4.15
4.16	54.00	RADIOLOGY-DIAGNOSTIC	SHARED EMPLOYEES	8,909	8,909	4.16
4.17	60.00	LABORATORY	SHARED EMPLOYEES	4,245,987	4,245,987	4.17
4.18	65.00	RESPIRATORY THERAPY		213	213	4.18
4.20	69.00	ELECTROCARDIOLOGY	SHARED EMPLOYEES	496,009	496,009	4.20
4.21	90.00	CLINIC	SHARED EMPLOYEES	58,372	58,372	4.21
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			36,489,832	20,019,696	5.00

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

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

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

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

	Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	
6.00	B		0.00	IU HEALTH, INC.	50.00	6.00
7.00	F		0.00	IUH BLOOMINGTO	50.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 15-1328 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-8-1 | Date/Time Prepared: 5/29/2024 2:18 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.	
	6.00	7.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:		
1.00	6,744,465	11	1.00
2.00	277,200	9	2.00
3.00	3,654,009	0	3.00
4.00	1,115,749	0	4.00
4.01	14,723	0	4.01
4.02	1,314,480	0	4.02
4.03	100,237	0	4.03
4.05	156,035	0	4.05
4.06	113,809	0	4.06
4.07	103,183	0	4.07
4.08	22,880	0	4.08
4.09	118,692	0	4.09
4.10	2,734,674	0	4.10
4.11	0	0	4.11
4.12	0	0	4.12
4.13	0	0	4.13
4.14	0	0	4.14
4.15	0	0	4.15
4.16	0	0	4.16
4.17	0	0	4.17
4.18	0	0	4.18
4.20	0	0	4.20
4.21	0	0	4.21
5.00	16,470,136		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.

	Type of Business	
6.00	HOME OFFICE	6.00
7.00	HEALTHCARE	7.00
8.00		8.00
9.00		9.00
10.00		10.00
100.00		100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 15-1328 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-8-2 | Date/Time Prepared: 5/29/2024 2:18 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	1,651,528	1,651,528	0	0	0	1.00
2.00	31.00	INTENSIVE CARE UNIT	413,106	413,106	0	0	0	2.00
3.00	50.00	OPERATING ROOM	1,375,628	1,375,628	0	0	0	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	42,323	42,323	0	0	0	4.00
5.00	60.00	LABORATORY	314,608	314,608	0	0	0	5.00
6.00	90.00	CLINIC	4,351	4,351	0	0	0	6.00
7.00	91.00	EMERGENCY	730,854	0	730,854	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			4,532,398	3,801,544	730,854		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	31.00	INTENSIVE CARE UNIT	0	0	0	0	0	2.00
3.00	50.00	OPERATING ROOM	0	0	0	0	0	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	4.00
5.00	60.00	LABORATORY	0	0	0	0	0	5.00
6.00	90.00	CLINIC	0	0	0	0	0	6.00
7.00	91.00	EMERGENCY	0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
	1.00	2.00	15.00	16.00	17.00	18.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	1,651,528	1.00
2.00	31.00	INTENSIVE CARE UNIT	0	0	0	413,106	2.00
3.00	50.00	OPERATING ROOM	0	0	0	1,375,628	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	42,323	4.00
5.00	60.00	LABORATORY	0	0	0	314,608	5.00
6.00	90.00	CLINIC	0	0	0	4,351	6.00
7.00	91.00	EMERGENCY	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	3,801,544	200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1328 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I Date/Time Prepared: 5/29/2024 2:18 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	798,751	798,751				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	1,964,092		1,964,092			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	3,677,550	2,196	7,390	3,687,136		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	15,837,557	109,410	368,183	117,551	16,432,701	5.00
7.00	00700	OPERATION OF PLANT	3,807,465	88,151	296,643	129,691	4,321,950	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	171,771	3,315	11,155	0	186,241	8.00
9.00	00900	HOUSEKEEPING	953,036	7,586	25,528	93,952	1,080,102	9.00
10.00	01000	DIETARY	529,520	16,015	53,894	49,547	648,976	10.00
11.00	01100	CAFETERIA	300,704	9,765	32,862	26,325	369,656	11.00
13.00	01300	NURSING ADMINISTRATION	2,236,611	26,816	90,241	310,105	2,663,773	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	770,672	18,646	62,746	17,816	869,880	14.00
15.00	01500	PHARMACY	1,873,140	8,930	30,052	154,245	2,066,367	15.00
17.00	01700	SOCIAL SERVICE	49,702	731	2,459	8,754	61,646	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,451,014	48,897	164,549	510,168	5,174,628	30.00
31.00	03100	INTENSIVE CARE UNIT	2,087,081	13,180	44,355	299,129	2,443,745	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,796,997	51,945	174,805	175,417	2,199,164	50.00
51.00	05100	RECOVERY ROOM	416,263	0	0	67,406	483,669	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,989,764	26,837	90,311	224,966	2,331,878	54.00
56.00	05600	RADIOISOTOPE	237,084	0	0	16,430	253,514	56.00
57.00	05700	CT SCAN	562,397	4,672	15,722	90,758	673,549	57.00
58.00	05800	MRI	380,728	4,480	15,075	48,217	448,500	58.00
60.00	06000	LABORATORY	4,661,070	19,560	65,822	56,867	4,803,319	60.00
65.00	06500	RESPIRATORY THERAPY	1,088,353	9,051	30,460	166,828	1,294,692	65.00
66.00	06600	PHYSICAL THERAPY	1,087,389	9,962	33,522	135,082	1,265,955	66.00
67.00	06700	OCCUPATIONAL THERAPY	332,419	5,294	17,815	54,944	410,472	67.00
68.00	06800	SPEECH PATHOLOGY	194,000	1,816	6,112	31,736	233,664	68.00
69.00	06900	ELECTROCARDIOLOGY	1,017,263	23,426	78,832	68,904	1,188,425	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	368,358	0	0	0	368,358	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	186,254	0	0	0	186,254	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	14,742,704	0	0	0	14,742,704	73.00
76.97	07697	CARDIAC REHABILITATION	85,185	1,578	5,311	13,225	105,299	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,379,547	31,772	106,917	204,057	1,722,293	90.00
90.01	09001	CLINIC - DIABETES	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	9,278,544	24,641	82,921	611,969	9,998,075	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	79,312,985	568,672	1,913,682	3,684,089	79,029,449	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	18,609	4,008	13,488	3,047	39,152	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	63,301	188,024	0	0	251,325	192.00
194.00	07950	OCCUPATIONAL HEALTH	5,480	10,972	36,922	0	53,374	194.00
194.02	07952	BLOOMNGTN AMBULANCE AND OCC MED	0	27,075	0	0	27,075	194.02
194.03	07953	HOME CARE	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	79,400,375	798,751	1,964,092	3,687,136	79,400,375	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1328 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I | Date/Time Prepared: 5/29/2024 2:18 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
	GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	16,432,701					5.00
7.00	00700	OPERATION OF PLANT	1,127,899	5,449,849				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	48,603	30,160	265,004			8.00
9.00	00900	HOUSEKEEPING	281,874	69,020	0	1,430,996		9.00
10.00	01000	DIETARY	169,363	145,712	0	61,443	1,025,494	10.00
11.00	01100	CAFETERIA	96,469	88,848	0	37,465	0	11.00
13.00	01300	NURSING ADMINISTRATION	695,165	243,981	0	102,880	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	227,013	169,643	0	71,534	0	14.00
15.00	01500	PHARMACY	539,260	81,251	0	34,261	0	15.00
17.00	01700	SOCIAL SERVICE	16,088	6,647	0	2,803	0	17.00
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,350,423	444,886	206,573	187,596	799,383	30.00
31.00	03100	INTENSIVE CARE UNIT	637,744	119,920	58,431	50,567	226,111	31.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	573,916	472,615	0	199,285	0	50.00
51.00	05100	RECOVERY ROOM	126,223	0	0	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	608,550	244,170	0	102,960	0	54.00
56.00	05600	RADIOISOTOPE	66,160	0	0	0	0	56.00
57.00	05700	CT SCAN	175,776	42,506	0	17,923	0	57.00
58.00	05800	MRI	117,045	40,758	0	17,187	0	58.00
60.00	06000	LABORATORY	1,253,522	177,962	0	75,042	0	60.00
65.00	06500	RESPIRATORY THERAPY	337,876	82,352	0	34,726	0	65.00
66.00	06600	PHYSICAL THERAPY	330,376	90,633	0	38,218	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	107,121	48,166	0	20,310	0	67.00
68.00	06800	SPEECH PATHOLOGY	60,979	16,524	0	6,968	0	68.00
69.00	06900	ELECTROCARDIOLOGY	310,143	213,136	0	89,874	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	96,130	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	48,607	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,847,431	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	27,480	14,359	0	6,055	0	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	449,467	289,069	0	121,893	0	90.00
90.01	09001	CLINIC - DIABETES	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	2,609,198	224,190	0	94,535	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
	OTHER REIMBURSABLE COST CENTERS							
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
	SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	16,335,901	3,356,508	265,004	1,373,525	1,025,494	118.00
	NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	10,217	36,466	0	15,377	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	65,588	1,710,713	0	0	0	192.00
194.00	07950	OCCUPATIONAL HEALTH	13,929	99,826	0	42,094	0	194.00
194.02	07952	BLOOMNGTN AMBULANCE AND OCC MED	7,066	246,336	0	0	0	194.02
194.03	07953	HOME CARE	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	16,432,701	5,449,849	265,004	1,430,996	1,025,494	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1328 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I | Date/Time Prepared: 5/29/2024 2:18 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	SOCIAL SERVICE	
			11.00	13.00	14.00	15.00	17.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	592,438					11.00
13.00	01300	NURSING ADMINISTRATION	40,504	3,746,303				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	5,903	0	1,343,973			14.00
15.00	01500	PHARMACY	21,610	0	21,623	2,764,372		15.00
17.00	01700	SOCIAL SERVICE	1,581	0	0	0	88,765	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	93,825	1,306,010	110,381	7,249	69,193	30.00
31.00	03100	INTENSIVE CARE UNIT	45,863	543,345	39,687	3,587	19,572	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	29,908	191,559	287,073	6,464	0	50.00
51.00	05100	RECOVERY ROOM	9,533	153,088	1,512	110	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	35,712	397	38,444	2,654	0	54.00
56.00	05600	RADIOISOTOPE	2,692	0	539	113	0	56.00
57.00	05700	CT SCAN	16,448	0	4,367	592	0	57.00
58.00	05800	MRI	9,138	0	519	57	0	58.00
60.00	06000	LABORATORY	52,111	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	30,822	0	70,614	0	0	65.00
66.00	06600	PHYSICAL THERAPY	24,623	0	129	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	9,089	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	4,569	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	11,015	93,995	25,851	386	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	388,082	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	196,227	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	2,708,211	0	73.00
76.97	07697	CARDIAC REHABILITATION	2,643	0	0	0	0	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	35,366	354,959	14,435	6,498	0	90.00
90.01	09001	CLINIC - DIABETES	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	108,396	1,102,950	144,456	28,451	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	591,351	3,746,303	1,343,939	2,764,372	88,765	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,087	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	34	0	0	192.00
194.00	07950	OCCUPATIONAL HEALTH	0	0	0	0	0	194.00
194.02	07952	BLOOMNGTN AMBULANCE AND OCC MED	0	0	0	0	0	194.02
194.03	07953	HOME CARE	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	592,438	3,746,303	1,343,973	2,764,372	88,765	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1328 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I | Date/Time Prepared: 5/29/2024 2:18 pm

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
17.00	01700	SOCIAL SERVICE					17.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	9,750,147	0	9,750,147		30.00
31.00	03100	INTENSIVE CARE UNIT	4,188,572	0	4,188,572		31.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	3,959,984	0	3,959,984		50.00
51.00	05100	RECOVERY ROOM	774,135	0	774,135		51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,364,765	0	3,364,765		54.00
56.00	05600	RADIOISOTOPE	323,018	0	323,018		56.00
57.00	05700	CT SCAN	931,161	0	931,161		57.00
58.00	05800	MRI	633,204	0	633,204		58.00
60.00	06000	LABORATORY	6,361,956	0	6,361,956		60.00
65.00	06500	RESPIRATORY THERAPY	1,851,082	0	1,851,082		65.00
66.00	06600	PHYSICAL THERAPY	1,749,934	0	1,749,934		66.00
67.00	06700	OCCUPATIONAL THERAPY	595,158	0	595,158		67.00
68.00	06800	SPEECH PATHOLOGY	322,704	0	322,704		68.00
69.00	06900	ELECTROCARDIOLOGY	1,932,825	0	1,932,825		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	852,570	0	852,570		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	431,088	0	431,088		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	21,298,346	0	21,298,346		73.00
76.97	07697	CARDIAC REHABILITATION	155,836	0	155,836		76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0		77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0		78.00
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	2,993,980	0	2,993,980		90.00
90.01	09001	CLINIC - DIABETES	0	0	0		90.01
91.00	09100	EMERGENCY	14,310,251	0	14,310,251		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0			92.00
		OTHER REIMBURSABLE COST CENTERS					
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0		102.00
		SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	76,780,716	0	76,780,716		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	102,299	0	102,299		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,027,660	0	2,027,660		192.00
194.00	07950	OCCUPATIONAL HEALTH	209,223	0	209,223		194.00
194.02	07952	BLOOMNGTN AMBULANCE AND OCC MED	280,477	0	280,477		194.02
194.03	07953	HOME CARE	0	0	0		194.03
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	79,400,375	0	79,400,375		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1328 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II Date/Time Prepared: 5/29/2024 2:18 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	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	2,196	7,390	9,586	9,586	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	109,410	368,183	477,593	306	5.00
7.00	00700	OPERATION OF PLANT	0	88,151	296,643	384,794	337	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	3,315	11,155	14,470	0	8.00
9.00	00900	HOUSEKEEPING	0	7,586	25,528	33,114	244	9.00
10.00	01000	DIETARY	0	16,015	53,894	69,909	129	10.00
11.00	01100	CAFETERIA	0	9,765	32,862	42,627	68	11.00
13.00	01300	NURSING ADMINISTRATION	0	26,816	90,241	117,057	806	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	18,646	62,746	81,392	46	14.00
15.00	01500	PHARMACY	0	8,930	30,052	38,982	401	15.00
17.00	01700	SOCIAL SERVICE	0	731	2,459	3,190	23	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	48,897	164,549	213,446	1,327	30.00
31.00	03100	INTENSIVE CARE UNIT	0	13,180	44,355	57,535	778	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	51,945	174,805	226,750	456	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	175	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	26,837	90,311	117,148	585	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	43	56.00
57.00	05700	CT SCAN	0	4,672	15,722	20,394	236	57.00
58.00	05800	MRI	0	4,480	15,075	19,555	125	58.00
60.00	06000	LABORATORY	0	19,560	65,822	85,382	148	60.00
65.00	06500	RESPIRATORY THERAPY	0	9,051	30,460	39,511	434	65.00
66.00	06600	PHYSICAL THERAPY	0	9,962	33,522	43,484	351	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	5,294	17,815	23,109	143	67.00
68.00	06800	SPEECH PATHOLOGY	0	1,816	6,112	7,928	83	68.00
69.00	06900	ELECTROCARDIOLOGY	0	23,426	78,832	102,258	179	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	1,578	5,311	6,889	34	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	31,772	106,917	138,689	531	90.00
90.01	09001	CLINIC - DIABETES	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	24,641	82,921	107,562	1,590	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	568,672	1,913,682	2,482,354	9,578	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	4,008	13,488	17,496	8	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	188,024	0	188,024	0	192.00
194.00	07950	OCCUPATIONAL HEALTH	0	10,972	36,922	47,894	0	194.00
194.02	07952	BLOOMNGTN AMBULANCE AND OCC MED	0	27,075	0	27,075	0	194.02
194.03	07953	HOME CARE	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	798,751	1,964,092	2,762,843	9,586	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1328 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II Date/Time Prepared: 5/29/2024 2:18 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	477,899					5.00
7.00	00700	OPERATION OF PLANT	32,804	417,935				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,414	2,313	18,197			8.00
9.00	00900	HOUSEKEEPING	8,198	5,293	0	46,849		9.00
10.00	01000	DIETARY	4,926	11,174	0	2,012	88,150	10.00
11.00	01100	CAFETERIA	2,806	6,814	0	1,227	0	11.00
13.00	01300	NURSING ADMINISTRATION	20,218	18,710	0	3,368	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	6,602	13,009	0	2,342	0	14.00
15.00	01500	PHARMACY	15,684	6,231	0	1,122	0	15.00
17.00	01700	SOCIAL SERVICE	468	510	0	92	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	39,275	34,117	14,185	6,142	68,714	30.00
31.00	03100	INTENSIVE CARE UNIT	18,548	9,196	4,012	1,655	19,436	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	16,692	36,244	0	6,523	0	50.00
51.00	05100	RECOVERY ROOM	3,671	0	0	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	17,699	18,725	0	3,371	0	54.00
56.00	05600	RADIOISOTOPE	1,924	0	0	0	0	56.00
57.00	05700	CT SCAN	5,112	3,260	0	587	0	57.00
58.00	05800	MRI	3,404	3,126	0	563	0	58.00
60.00	06000	LABORATORY	36,457	13,647	0	2,457	0	60.00
65.00	06500	RESPIRATORY THERAPY	9,827	6,315	0	1,137	0	65.00
66.00	06600	PHYSICAL THERAPY	9,609	6,950	0	1,251	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,115	3,694	0	665	0	67.00
68.00	06800	SPEECH PATHOLOGY	1,774	1,267	0	228	0	68.00
69.00	06900	ELECTROCARDIOLOGY	9,020	16,345	0	2,942	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,796	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,414	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	111,871	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	799	1,101	0	198	0	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	13,072	22,168	0	3,991	0	90.00
90.01	09001	CLINIC - DIABETES	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	75,885	17,193	0	3,095	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	475,084	257,402	18,197	44,968	88,150	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	297	2,796	0	503	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,908	131,191	0	0	0	192.00
194.00	07950	OCCUPATIONAL HEALTH	405	7,655	0	1,378	0	194.00
194.02	07952	BLOOMNGTN AMBULANCE AND OCC MED	205	18,891	0	0	0	194.02
194.03	07953	HOME CARE	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	477,899	417,935	18,197	46,849	88,150	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1328 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II | Date/Time Prepared: 5/29/2024 2:18 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	SOCIAL SERVICE	
			11.00	13.00	14.00	15.00	17.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	53,542					11.00
13.00	01300	NURSING ADMINISTRATION	3,661	163,820				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	533	0	103,924			14.00
15.00	01500	PHARMACY	1,953	0	1,672	66,045		15.00
17.00	01700	SOCIAL SERVICE	143	0	0	0	4,426	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,479	57,110	8,535	173	3,450	30.00
31.00	03100	INTENSIVE CARE UNIT	4,145	23,760	3,069	86	976	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,703	8,377	22,198	154	0	50.00
51.00	05100	RECOVERY ROOM	862	6,694	117	3	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,228	17	2,973	63	0	54.00
56.00	05600	RADIOISOTOPE	243	0	42	3	0	56.00
57.00	05700	CT SCAN	1,487	0	338	14	0	57.00
58.00	05800	MRI	826	0	40	1	0	58.00
60.00	06000	LABORATORY	4,710	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	2,786	0	5,460	0	0	65.00
66.00	06600	PHYSICAL THERAPY	2,225	0	10	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	821	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	413	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	995	4,110	1,999	9	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	30,009	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	15,173	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	64,704	0	73.00
76.97	07697	CARDIAC REHABILITATION	239	0	0	0	0	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	3,196	15,522	1,116	155	0	90.00
90.01	09001	CLINIC - DIABETES	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	9,796	48,230	11,170	680	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	53,444	163,820	103,921	66,045	4,426	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	98	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	3	0	0	192.00
194.00	07950	OCCUPATIONAL HEALTH	0	0	0	0	0	194.00
194.02	07952	BLOOMNGTN AMBULANCE AND OCC MED	0	0	0	0	0	194.02
194.03	07953	HOME CARE	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	53,542	163,820	103,924	66,045	4,426	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1328 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II Date/Time Prepared: 5/29/2024 2:18 pm

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
17.00	01700	SOCIAL SERVICE					17.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	454,953	0	454,953		30.00
31.00	03100	INTENSIVE CARE UNIT	143,196	0	143,196		31.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	320,097	0	320,097		50.00
51.00	05100	RECOVERY ROOM	11,522	0	11,522		51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	163,809	0	163,809		54.00
56.00	05600	RADIOISOTOPE	2,255	0	2,255		56.00
57.00	05700	CT SCAN	31,428	0	31,428		57.00
58.00	05800	MRI	27,640	0	27,640		58.00
60.00	06000	LABORATORY	142,801	0	142,801		60.00
65.00	06500	RESPIRATORY THERAPY	65,470	0	65,470		65.00
66.00	06600	PHYSICAL THERAPY	63,880	0	63,880		66.00
67.00	06700	OCCUPATIONAL THERAPY	31,547	0	31,547		67.00
68.00	06800	SPEECH PATHOLOGY	11,693	0	11,693		68.00
69.00	06900	ELECTROCARDIOLOGY	137,857	0	137,857		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	32,805	0	32,805		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	16,587	0	16,587		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	176,575	0	176,575		73.00
76.97	07697	CARDIAC REHABILITATION	9,260	0	9,260		76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0		77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0		78.00
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	198,440	0	198,440		90.00
90.01	09001	CLINIC - DIABETES	0	0	0		90.01
91.00	09100	EMERGENCY	275,201	0	275,201		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0			92.00
		OTHER REIMBURSABLE COST CENTERS					
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0		102.00
		SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,317,016	0	2,317,016		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	21,198	0	21,198		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	321,126	0	321,126		192.00
194.00	07950	OCCUPATIONAL HEALTH	57,332	0	57,332		194.00
194.02	07952	BLOOMNGTN AMBULANCE AND OCC MED	46,171	0	46,171		194.02
194.03	07953	HOME CARE	0	0	0		194.03
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	2,762,843	0	2,762,843		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1328 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/29/2024 2:18 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	191,318					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		139,797				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	526	526	20,935,026			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	26,206	26,206	667,435	-16,432,701	62,967,674	5.00
7.00	00700	OPERATION OF PLANT	21,114	21,114	736,364	0	4,321,950	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	794	794	0	0	186,241	8.00
9.00	00900	HOUSEKEEPING	1,817	1,817	533,445	0	1,080,102	9.00
10.00	01000	DIETARY	3,836	3,836	281,321	0	648,976	10.00
11.00	01100	CAFETERIA	2,339	2,339	149,471	0	369,656	11.00
13.00	01300	NURSING ADMINISTRATION	6,423	6,423	1,760,728	0	2,663,773	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	4,466	4,466	101,154	0	869,880	14.00
15.00	01500	PHARMACY	2,139	2,139	875,782	0	2,066,367	15.00
17.00	01700	SOCIAL SERVICE	175	175	49,702	0	61,646	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	11,712	11,712	2,896,660	0	5,174,628	30.00
31.00	03100	INTENSIVE CARE UNIT	3,157	3,157	1,698,411	0	2,443,745	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	12,442	12,442	995,994	0	2,199,164	50.00
51.00	05100	RECOVERY ROOM	0	0	382,722	0	483,669	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,428	6,428	1,277,325	0	2,331,878	54.00
56.00	05600	RADIOISOTOPE	0	0	93,287	0	253,514	56.00
57.00	05700	CT SCAN	1,119	1,119	515,308	0	673,549	57.00
58.00	05800	MRI	1,073	1,073	273,767	0	448,500	58.00
60.00	06000	LABORATORY	4,685	4,685	322,883	0	4,803,319	60.00
65.00	06500	RESPIRATORY THERAPY	2,168	2,168	947,227	0	1,294,692	65.00
66.00	06600	PHYSICAL THERAPY	2,386	2,386	766,975	0	1,265,955	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,268	1,268	311,963	0	410,472	67.00
68.00	06800	SPEECH PATHOLOGY	435	435	180,191	0	233,664	68.00
69.00	06900	ELECTROCARDIOLOGY	5,611	5,611	391,228	0	1,188,425	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	368,358	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	186,254	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	14,742,704	73.00
76.97	07697	CARDIAC REHABILITATION	378	378	75,090	0	105,299	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	7,610	7,610	1,158,606	0	1,722,293	90.00
90.01	09001	CLINIC - DIABETES	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	5,902	5,902	3,474,686	0	9,998,075	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	136,209	136,209	20,917,725	-16,432,701	62,596,748	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	960	960	17,301	0	39,152	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	45,036	0	0	0	251,325	192.00
194.00	07950	OCCUPATIONAL HEALTH	2,628	2,628	0	0	53,374	194.00
194.02	07952	BLOOMNGTN AMBULANCE AND OCC MED	6,485	0	0	0	27,075	194.02
194.03	07953	HOME CARE	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	798,751	1,964,092	3,687,136		16,432,701	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	4.174991	14.049600	0.176123		0.260970	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			9,586		477,899	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000458		0.007590	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: 15-1328 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/29/2024 2:18 pm

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (TOTAL PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (TOTAL PATIENT DAYS)	CAFETERIA (FTE)	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	143,472					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	794	6,735				8.00
9.00	00900	HOUSEKEEPING	1,817	0	89,340			9.00
10.00	01000	DIETARY	3,836	0	3,836	6,735		10.00
11.00	01100	CAFETERIA	2,339	0	2,339	0	23,988	11.00
13.00	01300	NURSING ADMINISTRATION	6,423	0	6,423	0	1,640	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	4,466	0	4,466	0	239	14.00
15.00	01500	PHARMACY	2,139	0	2,139	0	875	15.00
17.00	01700	SOCIAL SERVICE	175	0	175	0	64	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	11,712	5,250	11,712	5,250	3,799	30.00
31.00	03100	INTENSIVE CARE UNIT	3,157	1,485	3,157	1,485	1,857	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	12,442	0	12,442	0	1,211	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	386	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,428	0	6,428	0	1,446	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	109	56.00
57.00	05700	CT SCAN	1,119	0	1,119	0	666	57.00
58.00	05800	MRI	1,073	0	1,073	0	370	58.00
60.00	06000	LABORATORY	4,685	0	4,685	0	2,110	60.00
65.00	06500	RESPIRATORY THERAPY	2,168	0	2,168	0	1,248	65.00
66.00	06600	PHYSICAL THERAPY	2,386	0	2,386	0	997	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,268	0	1,268	0	368	67.00
68.00	06800	SPEECH PATHOLOGY	435	0	435	0	185	68.00
69.00	06900	ELECTROCARDIOLOGY	5,611	0	5,611	0	446	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	378	0	378	0	107	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	7,610	0	7,610	0	1,432	90.00
90.01	09001	CLINIC - DIABETES	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	5,902	0	5,902	0	4,389	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	88,363	6,735	85,752	6,735	23,944	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	960	0	960	0	44	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	45,036	0	0	0	0	192.00
194.00	07950	OCCUPATIONAL HEALTH	2,628	0	2,628	0	0	194.00
194.02	07952	BLOOMNGTN AMBULANCE AND OCC MED	6,485	0	0	0	0	194.02
194.03	07953	HOME CARE	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	5,449,849	265,004	1,430,996	1,025,494	592,438	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	37.985454	39.347290	16.017417	152.263400	24.697265	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	417,935	18,197	46,849	88,150	53,542	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	2.913007	2.701856	0.524390	13.088344	2.232033	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: 15-1328 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/29/2024 2:18 pm

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NRSING HR)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	SOCIAL SERVICE (TOTAL PATIENT DAYS)		
			13.00	14.00	15.00	17.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	9,446					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,275,666				14.00
15.00	01500	PHARMACY	0	20,524	15,048,438			15.00
17.00	01700	SOCIAL SERVICE	0	0	0	6,735		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,293	104,771	39,461	5,250		30.00
31.00	03100	INTENSIVE CARE UNIT	1,370	37,670	19,529	1,485		31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	483	272,483	35,188	0		50.00
51.00	05100	RECOVERY ROOM	386	1,435	601	0		51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1	36,490	14,448	0		54.00
56.00	05600	RADIOISOTOPE	0	512	615	0		56.00
57.00	05700	CT SCAN	0	4,145	3,225	0		57.00
58.00	05800	MRI	0	493	312	0		58.00
60.00	06000	LABORATORY	0	0	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	67,025	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	122	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	237	24,537	2,101	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	368,358	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	186,254	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	14,742,704	0		73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0		76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0		77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0		78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	895	13,701	35,374	0		90.00
90.01	09001	CLINIC - DIABETES	0	0	0	0		90.01
91.00	09100	EMERGENCY	2,781	137,114	154,880	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0		102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	9,446	1,275,634	15,048,438	6,735		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	32	0	0		192.00
194.00	07950	OCCUPATIONAL HEALTH	0	0	0	0		194.00
194.02	07952	BLOOMNGTN AMBULANCE AND OCC MED	0	0	0	0		194.02
194.03	07953	HOME CARE	0	0	0	0		194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	3,746,303	1,343,973	2,764,372	88,765		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	396.602054	1.053546	0.183698	13.179659		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	163,820	103,924	66,045	4,426		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	17.342791	0.081466	0.004389	0.657164		205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-1328 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I | Date/Time Prepared: 5/29/2024 2:18 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
					Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,750,147		9,750,147	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	4,188,572		4,188,572	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,959,984		3,959,984	0	0	50.00
51.00	05100	RECOVERY ROOM	774,135		774,135	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,364,765		3,364,765	0	0	54.00
56.00	05600	RADIOISOTOPE	323,018		323,018	0	0	56.00
57.00	05700	CT SCAN	931,161		931,161	0	0	57.00
58.00	05800	MRI	633,204		633,204	0	0	58.00
60.00	06000	LABORATORY	6,361,956		6,361,956	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,851,082	0	1,851,082	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,749,934	0	1,749,934	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	595,158	0	595,158	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	322,704	0	322,704	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,932,825		1,932,825	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	852,570		852,570	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	431,088		431,088	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	21,298,346		21,298,346	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	155,836		155,836	0	0	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0		0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0		0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2,993,980		2,993,980	0	0	90.00
90.01	09001	CLINIC - DIABETES	0		0	0	0	90.01
91.00	09100	EMERGENCY	14,310,251		14,310,251	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,025,953		2,025,953		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0		0		0	102.00
200.00		Subtotal (see instructions)	78,806,669	0	78,806,669	0	0	200.00
201.00		Less Observation Beds	2,025,953		2,025,953		0	201.00
202.00		Total (see instructions)	76,780,716	0	76,780,716	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-1328 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I | Date/Time Prepared: 5/29/2024 2:18 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	11,989,328		11,989,328			30.00
31.00	03100	INTENSIVE CARE UNIT	10,084,357		10,084,357			31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,994,028	33,137,833	36,131,861	0.109598	0.000000	50.00
51.00	05100	RECOVERY ROOM	184,630	6,966,960	7,151,590	0.108247	0.000000	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,212,611	18,010,984	19,223,595	0.175033	0.000000	54.00
56.00	05600	RADIOISOTOPE	477,281	3,655,487	4,132,768	0.078160	0.000000	56.00
57.00	05700	CT SCAN	1,363,972	15,687,705	17,051,677	0.054608	0.000000	57.00
58.00	05800	MRI	361,809	3,545,335	3,907,144	0.162063	0.000000	58.00
60.00	06000	LABORATORY	5,381,121	26,495,469	31,876,590	0.199581	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	1,820,405	5,503,369	7,323,774	0.252750	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	539,074	3,575,741	4,114,815	0.425276	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	550,756	1,636,311	2,187,067	0.272126	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	255,624	495,054	750,678	0.429883	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	2,100,283	11,636,890	13,737,173	0.140700	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	577,033	1,905,037	2,482,070	0.343492	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	208,552	952,338	1,160,890	0.371343	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	8,190,925	84,761,082	92,952,007	0.229133	0.000000	73.00
76.97	07697	CARDIAC REHABILITATION	0	1,733,652	1,733,652	0.089889	0.000000	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0.000000	0.000000	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0.000000	0.000000	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	13,726	18,099,175	18,112,901	0.165295	0.000000	90.00
90.01	09001	CLINIC - DIABETES	0	0	0	0.000000	0.000000	90.01
91.00	09100	EMERGENCY	2,229,321	63,285,861	65,515,182	0.218426	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	55,431	8,071,738	8,127,169	0.249282	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0			102.00
200.00		Subtotal (see instructions)	50,590,267	309,156,021	359,746,288			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	50,590,267	309,156,021	359,746,288			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1328 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 5/29/2024 2:18 pm

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.000000	50.00
51.00	05100	RECOVERY ROOM	0.000000	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
56.00	05600	RADIOISOTOPE	0.000000	56.00
57.00	05700	CT SCAN	0.000000	57.00
58.00	05800	MRI	0.000000	58.00
60.00	06000	LABORATORY	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	73.00
76.97	07697	CARDIAC REHABILITATION	0.000000	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000	78.00
		OUTPATIENT SERVICE COST CENTERS		
90.00	09000	CLINIC	0.000000	90.00
90.01	09001	CLINIC - DIABETES	0.000000	90.01
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS		
102.00	10200	OPIOID TREATMENT PROGRAM		102.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-1328 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I | Date/Time Prepared: 5/29/2024 2:18 pm

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
					Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,750,147		9,750,147	0	9,750,147	30.00
31.00	03100	INTENSIVE CARE UNIT	4,188,572		4,188,572	0	4,188,572	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,959,984		3,959,984	0	3,959,984	50.00
51.00	05100	RECOVERY ROOM	774,135		774,135	0	774,135	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,364,765		3,364,765	0	3,364,765	54.00
56.00	05600	RADIOISOTOPE	323,018		323,018	0	323,018	56.00
57.00	05700	CT SCAN	931,161		931,161	0	931,161	57.00
58.00	05800	MRI	633,204		633,204	0	633,204	58.00
60.00	06000	LABORATORY	6,361,956		6,361,956	0	6,361,956	60.00
65.00	06500	RESPIRATORY THERAPY	1,851,082	0	1,851,082	0	1,851,082	65.00
66.00	06600	PHYSICAL THERAPY	1,749,934	0	1,749,934	0	1,749,934	66.00
67.00	06700	OCCUPATIONAL THERAPY	595,158	0	595,158	0	595,158	67.00
68.00	06800	SPEECH PATHOLOGY	322,704	0	322,704	0	322,704	68.00
69.00	06900	ELECTROCARDIOLOGY	1,932,825		1,932,825	0	1,932,825	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	852,570		852,570	0	852,570	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	431,088		431,088	0	431,088	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	21,298,346		21,298,346	0	21,298,346	73.00
76.97	07697	CARDIAC REHABILITATION	155,836		155,836	0	155,836	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0		0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0		0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2,993,980		2,993,980	0	2,993,980	90.00
90.01	09001	CLINIC - DIABETES	0		0	0	0	90.01
91.00	09100	EMERGENCY	14,310,251		14,310,251	0	14,310,251	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,025,953		2,025,953		2,025,953	92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0		0		0	102.00
200.00		Subtotal (see instructions)	78,806,669	0	78,806,669	0	78,806,669	200.00
201.00		Less Observation Beds	2,025,953		2,025,953		2,025,953	201.00
202.00		Total (see instructions)	76,780,716	0	76,780,716	0	76,780,716	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1328 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 5/29/2024 2:18 pm

Title XIX | Hospital | PPS

		Cost Center Description	Charges Inpatient	Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	11,989,328		11,989,328			30.00
31.00	03100	INTENSIVE CARE UNIT	10,084,357		10,084,357			31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,994,028	33,137,833	36,131,861	0.109598	0.000000	50.00
51.00	05100	RECOVERY ROOM	184,630	6,966,960	7,151,590	0.108247	0.000000	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,212,611	18,010,984	19,223,595	0.175033	0.000000	54.00
56.00	05600	RADIOISOTOPE	477,281	3,655,487	4,132,768	0.078160	0.000000	56.00
57.00	05700	CT SCAN	1,363,972	15,687,705	17,051,677	0.054608	0.000000	57.00
58.00	05800	MRI	361,809	3,545,335	3,907,144	0.162063	0.000000	58.00
60.00	06000	LABORATORY	5,381,121	26,495,469	31,876,590	0.199581	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	1,820,405	5,503,369	7,323,774	0.252750	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	539,074	3,575,741	4,114,815	0.425276	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	550,756	1,636,311	2,187,067	0.272126	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	255,624	495,054	750,678	0.429883	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	2,100,283	11,636,890	13,737,173	0.140700	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	577,033	1,905,037	2,482,070	0.343492	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	208,552	952,338	1,160,890	0.371343	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	8,190,925	84,761,082	92,952,007	0.229133	0.000000	73.00
76.97	07697	CARDIAC REHABILITATION	0	1,733,652	1,733,652	0.089889	0.000000	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0.000000	0.000000	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0.000000	0.000000	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	13,726	18,099,175	18,112,901	0.165295	0.000000	90.00
90.01	09001	CLINIC - DIABETES	0	0	0	0.000000	0.000000	90.01
91.00	09100	EMERGENCY	2,229,321	63,285,861	65,515,182	0.218426	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	55,431	8,071,738	8,127,169	0.249282	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0			102.00
200.00		Subtotal (see instructions)	50,590,267	309,156,021	359,746,288			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	50,590,267	309,156,021	359,746,288			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1328 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 5/29/2024 2:18 pm

Title XIX | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.109598	50.00
51.00	05100	RECOVERY ROOM	0.108247	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.175033	54.00
56.00	05600	RADIOISOTOPE	0.078160	56.00
57.00	05700	CT SCAN	0.054608	57.00
58.00	05800	MRI	0.162063	58.00
60.00	06000	LABORATORY	0.199581	60.00
65.00	06500	RESPIRATORY THERAPY	0.252750	65.00
66.00	06600	PHYSICAL THERAPY	0.425276	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.272126	67.00
68.00	06800	SPEECH PATHOLOGY	0.429883	68.00
69.00	06900	ELECTROCARDIOLOGY	0.140700	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.343492	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.371343	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.229133	73.00
76.97	07697	CARDIAC REHABILITATION	0.089889	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000	78.00
		OUTPATIENT SERVICE COST CENTERS		
90.00	09000	CLINIC	0.165295	90.00
90.01	09001	CLINIC - DIABETES	0.000000	90.01
91.00	09100	EMERGENCY	0.218426	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.249282	92.00
		OTHER REIMBURSABLE COST CENTERS		
102.00	10200	OPIOID TREATMENT PROGRAM		102.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

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

Provider CCN: 15-1328 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part II | Date/Time Prepared: 5/29/2024 2:18 pm

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	3,959,984	320,097	3,639,887	0	0	50.00
51.00	05100	RECOVERY ROOM	774,135	11,522	762,613	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,364,765	163,809	3,200,956	0	0	54.00
56.00	05600	RADIOISOTOPE	323,018	2,255	320,763	0	0	56.00
57.00	05700	CT SCAN	931,161	31,428	899,733	0	0	57.00
58.00	05800	MRI	633,204	27,640	605,564	0	0	58.00
60.00	06000	LABORATORY	6,361,956	142,801	6,219,155	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,851,082	65,470	1,785,612	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,749,934	63,880	1,686,054	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	595,158	31,547	563,611	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	322,704	11,693	311,011	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,932,825	137,857	1,794,968	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	852,570	32,805	819,765	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	431,088	16,587	414,501	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	21,298,346	176,575	21,121,771	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	155,836	9,260	146,576	0	0	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2,993,980	198,440	2,795,540	0	0	90.00
90.01	09001	CLINIC - DIABETES	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	14,310,251	275,201	14,035,050	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,025,953	94,533	1,931,420	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
200.00		Subtotal (sum of lines 50 thru 199)	64,867,950	1,813,400	63,054,550	0	0	200.00
201.00		Less Observation Beds	2,025,953	94,533	1,931,420	0	0	201.00
202.00		Total (line 200 minus line 201)	62,841,997	1,718,867	61,123,130	0	0	202.00

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

Provider CCN: 15-1328 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part II | Date/Time Prepared: 5/29/2024 2:18 pm

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	3,959,984	36,131,861	0.109598	50.00
51.00	05100	RECOVERY ROOM	774,135	7,151,590	0.108247	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,364,765	19,223,595	0.175033	54.00
56.00	05600	RADIOISOTOPE	323,018	4,132,768	0.078160	56.00
57.00	05700	CT SCAN	931,161	17,051,677	0.054608	57.00
58.00	05800	MRI	633,204	3,907,144	0.162063	58.00
60.00	06000	LABORATORY	6,361,956	31,876,590	0.199581	60.00
65.00	06500	RESPIRATORY THERAPY	1,851,082	7,323,774	0.252750	65.00
66.00	06600	PHYSICAL THERAPY	1,749,934	4,114,815	0.425276	66.00
67.00	06700	OCCUPATIONAL THERAPY	595,158	2,187,067	0.272126	67.00
68.00	06800	SPEECH PATHOLOGY	322,704	750,678	0.429883	68.00
69.00	06900	ELECTROCARDIOLOGY	1,932,825	13,737,173	0.140700	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	852,570	2,482,070	0.343492	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	431,088	1,160,890	0.371343	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	21,298,346	92,952,007	0.229133	73.00
76.97	07697	CARDIAC REHABILITATION	155,836	1,733,652	0.089889	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0.000000	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0.000000	78.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	2,993,980	18,112,901	0.165295	90.00
90.01	09001	CLINIC - DIABETES	0	0	0.000000	90.01
91.00	09100	EMERGENCY	14,310,251	65,515,182	0.218426	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,025,953	8,127,169	0.249282	92.00
		OTHER REIMBURSABLE COST CENTERS				
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0.000000	102.00
200.00		Subtotal (sum of lines 50 thru 199)	64,867,950	337,672,603		200.00
201.00		Less Observation Beds	2,025,953	0		201.00
202.00		Total (line 200 minus line 201)	62,841,997	337,672,603		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-1328 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part II Date/Time Prepared: 5/29/2024 2:18 pm

Title XVIII | Hospital | Cost

		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	320,097	36,131,861	0.008859	756,360	6,701	50.00
51.00	05100	RECOVERY ROOM	11,522	7,151,590	0.001611	50,255	81	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	163,809	19,223,595	0.008521	493,309	4,203	54.00
56.00	05600	RADIOISOTOPE	2,255	4,132,768	0.000546	134,445	73	56.00
57.00	05700	CT SCAN	31,428	17,051,677	0.001843	318,575	587	57.00
58.00	05800	MRI	27,640	3,907,144	0.007074	137,866	975	58.00
60.00	06000	LABORATORY	142,801	31,876,590	0.004480	1,933,863	8,664	60.00
65.00	06500	RESPIRATORY THERAPY	65,470	7,323,774	0.008939	616,429	5,510	65.00
66.00	06600	PHYSICAL THERAPY	63,880	4,114,815	0.015524	228,992	3,555	66.00
67.00	06700	OCCUPATIONAL THERAPY	31,547	2,187,067	0.014424	234,154	3,377	67.00
68.00	06800	SPEECH PATHOLOGY	11,693	750,678	0.015577	127,681	1,989	68.00
69.00	06900	ELECTROCARDIOLOGY	137,857	13,737,173	0.010035	835,951	8,389	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	32,805	2,482,070	0.013217	185,699	2,454	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	16,587	1,160,890	0.014288	55,224	789	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	176,575	92,952,007	0.001900	2,926,378	5,560	73.00
76.97	07697	CARDIAC REHABILITATION	9,260	1,733,652	0.005341	0	0	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0.000000	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0.000000	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	198,440	18,112,901	0.010956	0	0	90.00
90.01	09001	CLINIC - DIABETES	0	0	0.000000	0	0	90.01
91.00	09100	EMERGENCY	275,201	65,515,182	0.004201	104,858	441	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	94,533	8,127,169	0.011632	18,264	212	92.00
200.00		Total (lines 50 through 199)	1,813,400	337,672,603		9,158,303	53,560	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1328 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV | Date/Time Prepared: 5/29/2024 2:18 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	CLINIC - DIABETES	0	0	0	0	0	90.01
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: 15-1328 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV Date/Time Prepared: 5/29/2024 2:18 pm

Title XVIII | Hospital | Cost

		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	36,131,861	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	7,151,590	0.000000	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	19,223,595	0.000000	54.00
56.00	05600	RADIOISOTOPE	0	0	0	4,132,768	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	17,051,677	0.000000	57.00
58.00	05800	MRI	0	0	0	3,907,144	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	31,876,590	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	7,323,774	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	4,114,815	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	2,187,067	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	750,678	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	13,737,173	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	2,482,070	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,160,890	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	92,952,007	0.000000	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	1,733,652	0.000000	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0.000000	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0.000000	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	18,112,901	0.000000	90.00
90.01	09001	CLINIC - DIABETES	0	0	0	0	0.000000	90.01
91.00	09100	EMERGENCY	0	0	0	65,515,182	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	8,127,169	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	337,672,603		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1328 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV Date/Time Prepared: 5/29/2024 2:18 pm

Title XVIII | Hospital | Cost

		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	756,360	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	50,255	0	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	493,309	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0.000000	134,445	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	318,575	0	0	0	57.00
58.00	05800	MRI	0.000000	137,866	0	0	0	58.00
60.00	06000	LABORATORY	0.000000	1,933,863	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	616,429	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	228,992	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	234,154	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	127,681	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	835,951	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	185,699	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	55,224	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	2,926,378	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	CLINIC - DIABETES	0.000000	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.000000	104,858	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	18,264	0	0	0	92.00
200.00		Total (lines 50 through 199)		9,158,303	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-1328 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part V | Date/Time Prepared: 5/29/2024 2:18 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.109598	0	6,176,973	0	0	50.00
51.00	05100	RECOVERY ROOM	0.108247	0	1,330,012	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.175033	0	3,345,372	0	0	54.00
56.00	05600	RADIOISOTOPE	0.078160	0	1,068,865	0	0	56.00
57.00	05700	CT SCAN	0.054608	0	4,126,143	0	0	57.00
58.00	05800	MRI	0.162063	0	753,820	0	0	58.00
60.00	06000	LABORATORY	0.199581	0	6,009,553	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.252750	0	1,280,765	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.425276	0	895,859	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.272126	0	417,308	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.429883	0	55,483	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.140700	0	2,616,547	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.343492	0	255,690	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.371343	0	152,322	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.229133	0	34,502,644	3,694	0	73.00
76.97	07697	CARDIAC REHABILITATION	0.089889	0	697,382	0	0	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.165295	0	5,916,273	679	0	90.00
90.01	09001	CLINIC - DIABETES	0.000000	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.218426	0	12,995,770	448	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.249282	0	1,837,066	1,345	0	92.00
200.00		Subtotal (see instructions)		0	84,433,847	6,166	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	84,433,847	6,166	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1328 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part V Date/Time Prepared: 5/29/2024 2:18 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Costs		
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	676,984	0	50.00
51.00	05100	RECOVERY ROOM	143,970	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	585,550	0	54.00
56.00	05600	RADIOISOTOPE	83,542	0	56.00
57.00	05700	CT SCAN	225,320	0	57.00
58.00	05800	MRI	122,166	0	58.00
60.00	06000	LABORATORY	1,199,393	0	60.00
65.00	06500	RESPIRATORY THERAPY	323,713	0	65.00
66.00	06600	PHYSICAL THERAPY	380,987	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	113,560	0	67.00
68.00	06800	SPEECH PATHOLOGY	23,851	0	68.00
69.00	06900	ELECTROCARDIOLOGY	368,148	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	87,827	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	56,564	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,905,694	846	73.00
76.97	07697	CARDIAC REHABILITATION	62,687	0	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	977,930	112	90.00
90.01	09001	CLINIC - DIABETES	0	0	90.01
91.00	09100	EMERGENCY	2,838,614	98	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	457,947	335	92.00
200.00		Subtotal (see instructions)	16,634,447	1,391	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	16,634,447	1,391	202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 15-1328 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part I Date/Time Prepared: 5/29/2024 2:18 pm

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	454,953	0	454,953	6,627	68.65	30.00
31.00	INTENSIVE CARE UNIT	143,196		143,196	1,485	96.43	31.00
200.00	Total (lines 30 through 199)	598,149		598,149	8,112		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	111	7,620	30.00
31.00	INTENSIVE CARE UNIT	37	3,568	31.00
200.00	Total (lines 30 through 199)	148	11,188	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-1328 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part II Date/Time Prepared: 5/29/2024 2:18 pm

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	320,097	36,131,861	0.008859	8,140	72	50.00
51.00	05100	RECOVERY ROOM	11,522	7,151,590	0.001611	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	163,809	19,223,595	0.008521	19,634	167	54.00
56.00	05600	RADIOISOTOPE	2,255	4,132,768	0.000546	4,308	2	56.00
57.00	05700	CT SCAN	31,428	17,051,677	0.001843	44,677	82	57.00
58.00	05800	MRI	27,640	3,907,144	0.007074	1,744	12	58.00
60.00	06000	LABORATORY	142,801	31,876,590	0.004480	137,028	614	60.00
65.00	06500	RESPIRATORY THERAPY	65,470	7,323,774	0.008939	50,043	447	65.00
66.00	06600	PHYSICAL THERAPY	63,880	4,114,815	0.015524	7,139	111	66.00
67.00	06700	OCCUPATIONAL THERAPY	31,547	2,187,067	0.014424	8,735	126	67.00
68.00	06800	SPEECH PATHOLOGY	11,693	750,678	0.015577	5,955	93	68.00
69.00	06900	ELECTROCARDIOLOGY	137,857	13,737,173	0.010035	42,196	423	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	32,805	2,482,070	0.013217	7,029	93	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	16,587	1,160,890	0.014288	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	176,575	92,952,007	0.001900	232,898	443	73.00
76.97	07697	CARDIAC REHABILITATION	9,260	1,733,652	0.005341	0	0	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0.000000	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0.000000	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	198,440	18,112,901	0.010956	0	0	90.00
90.01	09001	CLINIC - DIABETES	0	0	0.000000	0	0	90.01
91.00	09100	EMERGENCY	275,201	65,515,182	0.004201	198,842	835	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	94,533	8,127,169	0.011632	0	0	92.00
200.00		Total (lines 50 through 199)	1,813,400	337,672,603		768,368	3,520	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1328 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part III Date/Time Prepared: 5/29/2024 2:18 pm

Title XIX | Hospital | PPS

		Cost Center Description	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
			1A	1.00	2A	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
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	6,627	0.00	111	30.00
31.00	03100	INTENSIVE CARE UNIT		0	1,485	0.00	37	31.00
200.00		Total (lines 30 through 199)		0	8,112		148	200.00

		Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
			9.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	31.00
200.00		Total (lines 30 through 199)	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1328 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV Date/Time Prepared: 5/29/2024 2:18 pm

Title XIX | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	CLINIC - DIABETES	0	0	0	0	0	90.01
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: 15-1328 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV | Date/Time Prepared: 5/29/2024 2:18 pm

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	36,131,861	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	7,151,590	0.000000	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	19,223,595	0.000000	54.00
56.00	05600	RADIOISOTOPE	0	0	0	4,132,768	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	17,051,677	0.000000	57.00
58.00	05800	MRI	0	0	0	3,907,144	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	31,876,590	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	7,323,774	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	4,114,815	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	2,187,067	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	750,678	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	13,737,173	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	2,482,070	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,160,890	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	92,952,007	0.000000	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	1,733,652	0.000000	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0.000000	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0.000000	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	18,112,901	0.000000	90.00
90.01	09001	CLINIC - DIABETES	0	0	0	0	0.000000	90.01
91.00	09100	EMERGENCY	0	0	0	65,515,182	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	8,127,169	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	337,672,603		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1328 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV | Date/Time Prepared: 5/29/2024 2:18 pm

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	8,140	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	19,634	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0.000000	4,308	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	44,677	0	0	0	57.00
58.00	05800	MRI	0.000000	1,744	0	0	0	58.00
60.00	06000	LABORATORY	0.000000	137,028	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	50,043	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	7,139	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	8,735	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	5,955	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	42,196	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	7,029	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	232,898	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	CLINIC - DIABETES	0.000000	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.000000	198,842	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		768,368	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1328 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part V Date/Time Prepared: 5/29/2024 2:18 pm

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	0.109598	0	272,903	0	0	50.00
51.00	05100	RECOVERY ROOM	0.108247	0	53,200	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.175033	0	180,058	0	0	54.00
56.00	05600	RADIOISOTOPE	0.078160	0	22,809	0	0	56.00
57.00	05700	CT SCAN	0.054608	0	186,391	0	0	57.00
58.00	05800	MRI	0.162063	0	35,074	0	0	58.00
60.00	06000	LABORATORY	0.199581	0	336,604	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.252750	0	68,999	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.425276	0	22,890	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.272126	0	13,319	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.429883	0	2,462	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.140700	0	106,120	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.343492	0	20,526	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.371343	0	1,990	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.229133	0	1,415,542	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0.089889	0	12,473	0	0	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.165295	0	391,035	0	0	90.00
90.01	09001	CLINIC - DIABETES	0.000000	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.218426	0	1,137,894	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.249282	0	73,919	0	0	92.00
200.00		Subtotal (see instructions)		0	4,354,208	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	4,354,208	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1328 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part V Date/Time Prepared: 5/29/2024 2:18 pm

Title XIX | Hospital | PPS

		Cost Center Description	Costs		
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	29,910	0	50.00
51.00	05100	RECOVERY ROOM	5,759	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	31,516	0	54.00
56.00	05600	RADIOISOTOPE	1,783	0	56.00
57.00	05700	CT SCAN	10,178	0	57.00
58.00	05800	MRI	5,684	0	58.00
60.00	06000	LABORATORY	67,180	0	60.00
65.00	06500	RESPIRATORY THERAPY	17,439	0	65.00
66.00	06600	PHYSICAL THERAPY	9,735	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,624	0	67.00
68.00	06800	SPEECH PATHOLOGY	1,058	0	68.00
69.00	06900	ELECTROCARDIOLOGY	14,931	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	7,051	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	739	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	324,347	0	73.00
76.97	07697	CARDIAC REHABILITATION	1,121	0	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	64,636	0	90.00
90.01	09001	CLINIC - DIABETES	0	0	90.01
91.00	09100	EMERGENCY	248,546	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	18,427	0	92.00
200.00		Subtotal (see instructions)	863,664	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	863,664	0	202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1328 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/29/2024 2:18 pm

Title XVIII | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	6,627	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	6,627	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)	5,250	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	2,162	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		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	266.32	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)	9,750,147	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)	9,750,147	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)	9,750,147	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)	1,471.28	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	3,180,907	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)	3,180,907	41.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-1328	Period: From 01/01/2023 To 12/31/2023	Worksheet D-1 Date/Time Prepared: 5/29/2024 2:18 pm
	Title XVIII	Hospital	Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	4,188,572	1,485	2,820.59	562	1,585,172	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	1,882,583	48.00
48.01	Program inpatient cellular therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1)	0	48.01
49.00	Total Program inpatient costs (sum of lines 41 through 48.01)(see instructions)	6,648,662	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
55.01	Permanent adjustment amount per discharge	0.00	55.01
55.02	Adjustment amount per discharge (contractor use only)	0.00	55.02
56.00	Target amount (line 54 x sum of lines 55, 55.01, and 55.02)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)	0.00	59.00
60.00	Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)	0.00	60.00
61.00	Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	1,377	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,471.28	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	2,025,953	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-1328 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/29/2024 2:18 pm

Title XVIII | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	454,953	9,750,147	0.046661	2,025,953	94,533	90.00
91.00	Nursing Program cost	0	9,750,147	0.000000	2,025,953	0	91.00
92.00	Allied health cost	0	9,750,147	0.000000	2,025,953	0	92.00
93.00	All other Medical Education	0	9,750,147	0.000000	2,025,953	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1328 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 Date/Time Prepared: 5/29/2024 2:18 pm

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)	6,627	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	6,627	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)	5,250	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)	111	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		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		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)	9,750,147	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)	9,750,147	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)	9,750,147	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)	1,471.28	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	163,312	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)	163,312	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1328 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/29/2024 2:18 pm

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)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	4,188,572	1,485	2,820.59	37	104,362	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	160,506	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)	428,180	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)	11,188	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	3,520	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	14,708	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	413,472	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)	1,377	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,471.28	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	2,025,953	89.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-1328	Period: From 01/01/2023 To 12/31/2023	Worksheet D-1 Date/Time Prepared: 5/29/2024 2:18 pm
	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	454,953	9,750,147	0.046661	2,025,953	94,533	90.00
91.00	Nursing Program cost	0	9,750,147	0.000000	2,025,953	0	91.00
92.00	Allied health cost	0	9,750,147	0.000000	2,025,953	0	92.00
93.00	All other Medical Education	0	9,750,147	0.000000	2,025,953	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1328 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-3 | Date/Time Prepared: 5/29/2024 2:18 pm

Title XVIII | Hospital | Cost

Line	Code	Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	Line
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		4,764,743		30.00
31.00	03100	INTENSIVE CARE UNIT		3,737,627		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.109598	756,360	82,896	50.00
51.00	05100	RECOVERY ROOM	0.108247	50,255	5,440	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.175033	493,309	86,345	54.00
56.00	05600	RADIOISOTOPE	0.078160	134,445	10,508	56.00
57.00	05700	CT SCAN	0.054608	318,575	17,397	57.00
58.00	05800	MRI	0.162063	137,866	22,343	58.00
60.00	06000	LABORATORY	0.199581	1,933,863	385,962	60.00
65.00	06500	RESPIRATORY THERAPY	0.252750	616,429	155,802	65.00
66.00	06600	PHYSICAL THERAPY	0.425276	228,992	97,385	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.272126	234,154	63,719	67.00
68.00	06800	SPEECH PATHOLOGY	0.429883	127,681	54,888	68.00
69.00	06900	ELECTROCARDIOLOGY	0.140700	835,951	117,618	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.343492	185,699	63,786	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.371343	55,224	20,507	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.229133	2,926,378	670,530	73.00
76.97	07697	CARDIAC REHABILITATION	0.089889	0	0	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.165295	0	0	90.00
90.01	09001	CLINIC - DIABETES	0.000000	0	0	90.01
91.00	09100	EMERGENCY	0.218426	104,858	22,904	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.249282	18,264	4,553	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		9,158,303	1,882,583	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)		9,158,303		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-1328 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-3

Component CCN: 15-Z328 | Date/Time Prepared: 5/29/2024 2:18 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.109598	0	0	50.00
51.00	05100	RECOVERY ROOM	0.108247	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.175033	0	0	54.00
56.00	05600	RADIOISOTOPE	0.078160	0	0	56.00
57.00	05700	CT SCAN	0.054608	0	0	57.00
58.00	05800	MRI	0.162063	0	0	58.00
60.00	06000	LABORATORY	0.199581	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.252750	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.425276	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.272126	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.429883	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.140700	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.343492	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.371343	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.229133	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0.089889	0	0	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.165295	0	0	90.00
90.01	09001	CLINIC - DIABETES	0.000000	0	0	90.01
91.00	09100	EMERGENCY	0.218426	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.249282	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		0	0	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)		0		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1328 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-3 | Date/Time Prepared: 5/29/2024 2:18 pm

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		241,426		30.00
31.00	03100	INTENSIVE CARE UNIT		240,589		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.109598	8,140	892	50.00
51.00	05100	RECOVERY ROOM	0.108247	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.175033	19,634	3,437	54.00
56.00	05600	RADIOISOTOPE	0.078160	4,308	337	56.00
57.00	05700	CT SCAN	0.054608	44,677	2,440	57.00
58.00	05800	MRI	0.162063	1,744	283	58.00
60.00	06000	LABORATORY	0.199581	137,028	27,348	60.00
65.00	06500	RESPIRATORY THERAPY	0.252750	50,043	12,648	65.00
66.00	06600	PHYSICAL THERAPY	0.425276	7,139	3,036	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.272126	8,735	2,377	67.00
68.00	06800	SPEECH PATHOLOGY	0.429883	5,955	2,560	68.00
69.00	06900	ELECTROCARDIOLOGY	0.140700	42,196	5,937	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.343492	7,029	2,414	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.371343	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.229133	232,898	53,365	73.00
76.97	07697	CARDIAC REHABILITATION	0.089889	0	0	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.165295	0	0	90.00
90.01	09001	CLINIC - DIABETES	0.000000	0	0	90.01
91.00	09100	EMERGENCY	0.218426	198,842	43,432	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.249282	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		768,368	160,506	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)		768,368		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-1328 | Component CCN: 15-Z328 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-3 | Date/Time Prepared: 5/29/2024 2:18 pm

Title XIX | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.109598	0	0	50.00
51.00	05100	RECOVERY ROOM	0.108247	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.175033	0	0	54.00
56.00	05600	RADIOISOTOPE	0.078160	0	0	56.00
57.00	05700	CT SCAN	0.054608	0	0	57.00
58.00	05800	MRI	0.162063	0	0	58.00
60.00	06000	LABORATORY	0.199581	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.252750	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.425276	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.272126	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.429883	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.140700	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.343492	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.371343	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.229133	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0.089889	0	0	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.165295	0	0	90.00
90.01	09001	CLINIC - DIABETES	0.000000	0	0	90.01
91.00	09100	EMERGENCY	0.218426	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.249282	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		0	0	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)		0		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-1328 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E Part B Date/Time Prepared: 5/29/2024 2:18 pm

Title XVIII | Hospital | Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	16,635,838	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	OPPS or REH payments	0	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)	16,635,838	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	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)	0	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)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	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)	16,802,196	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)	0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	120,820	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	15,292,109	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)	1,389,267	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)	1,389,267	30.00
31.00	Primary payer payments	85	31.00
32.00	Subtotal (line 30 minus line 31)	1,389,182	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33.00	Composite rate ESRD (from Wkst. I-5, line 11)	0	33.00
34.00	Allowable bad debts (see instructions)	1,293,657	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	840,877	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	1,032,791	36.00
37.00	Subtotal (see instructions)	2,230,059	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)	2,230,059	40.00
40.01	Sequestration adjustment (see instructions)	44,601	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	2,065,878	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)	119,580	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	1,303,668	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: 15-1328 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E Part B Date/Time Prepared: 5/29/2024 2:18 pm

	Title XVIII	Hospital	Cost
		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: 15-1328 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E-1 Part I Date/Time Prepared: 5/29/2024 2:18 pm

Title XVIII | Hospital | Cost

		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		6,407,991		2,065,878	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	09/29/2023	182,000		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)		182,000		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)		6,589,991		2,065,878	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		0		119,580	6.01
6.02	SETTLEMENT TO PROGRAM		782,379		0	6.02
7.00	Total Medicare program liability (see instructions)		5,807,612		2,185,458	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-1328
Component CCN: 15-Z328

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

Worksheet E-1 Part I
Date/Time Prepared: 5/29/2024 2:18 pm

Title XVIII | Swing Beds - SNF | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		0		0	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)		0		0	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		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		0		0	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: 15-1328	Period: From 01/01/2023 To 12/31/2023	Worksheet E-1 Part II Date/Time Prepared: 5/29/2024 2:18 pm
	Title XVIII	Hospital	Cost

		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 - SWING BEDS

Provider CCN: 15-1328 | Component CCN: 15-Z328 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E-2 | Date/Time Prepared: 5/29/2024 2:18 pm

Title XVIII | Swing Beds - SNF | Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	0	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swing-bed pass-through, see instructions)	0	0	3.00
3.01	Nursing and allied health payment-PARHM (see instructions)			3.01
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days	0	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	0	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	0	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	0	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	0	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (see instructions)	0	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)			16.50
16.55	Rural community hospital demonstration project (§410A Demonstration) payment adjustment (see instructions)	0		16.55
16.99	Demonstration payment adjustment amount before sequestration	0	0	16.99
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	0	0	19.00
19.01	Sequestration adjustment (see instructions)	0	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)	0	0	19.02
19.03	Sequestration adjustment-PARHM pass-throughs			19.03
19.25	Sequestration for non-claims based amounts (see instructions)	0	0	19.25
20.00	Interim payments	0	0	20.00
20.01	Interim payments-PARHM			20.01
21.00	Tentative settlement (for contractor use only)	0	0	21.00
21.01	Tentative settlement-PARHM (for contractor use only)			21.01
22.00	Balance due provider/program (line 19 minus lines 19.01, 19.02, 19.25, 20, and 21)	0	0	22.00
22.01	Balance due provider/program-PARHM (see instructions)			22.01
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	23.00
	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 swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))			201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))			202.00
203.00	Total (sum of lines 201 and 202)			203.00
204.00	Medicare swing-bed SNF discharges (see instructions)			204.00
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)			
205.00	Medicare swing-bed SNF target amount			205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)			206.00
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement			
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)			208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
	Comparision of PPS versus Cost Reimbursement			
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)			215.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS | Provider CCN: 15-1328 | Component CCN: 15-Z328 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E-2 | Date/Time Prepared: 5/29/2024 2:18 pm

Title XIX | Swing Beds - SNF | Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	0		1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)	0		2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swing-bed pass-through, see instructions)	0		3.00
3.01	Nursing and allied health payment-PARHM (see instructions)			3.01
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)	0.00		4.00
5.00	Program days	0		5.00
6.00	Interns and residents not in approved teaching program (see instructions)	0		6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	0		8.00
9.00	Primary payer payments (see instructions)	0		9.00
10.00	Subtotal (line 8 minus line 9)	0		10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0		11.00
12.00	Subtotal (line 10 minus line 11)	0		12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	0		13.00
14.00	80% of Part B costs (line 12 x 80%)	0		14.00
15.00	Subtotal (see instructions)	0		15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0		16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)			16.50
16.55	Rural community hospital demonstration project (§410A Demonstration) payment adjustment (see instructions)			16.55
16.99	Demonstration payment adjustment amount before sequestration	0		16.99
17.00	Allowable bad debts (see instructions)	0		17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0		17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0		18.00
19.00	Total (see instructions)	0		19.00
19.01	Sequestration adjustment (see instructions)	0		19.01
19.02	Demonstration payment adjustment amount after sequestration)	0		19.02
19.03	Sequestration adjustment-PARHM pass-throughs			19.03
19.25	Sequestration for non-claims based amounts (see instructions)	0		19.25
20.00	Interim payments	0		20.00
20.01	Interim payments-PARHM			20.01
21.00	Tentative settlement (for contractor use only)	0		21.00
21.01	Tentative settlement-PARHM (for contractor use only)			21.01
22.00	Balance due provider/program (line 19 minus lines 19.01, 19.02, 19.25, 20, and 21)	0		22.00
22.01	Balance due provider/program-PARHM (see instructions)			22.01
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0		23.00
	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 swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))			201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))			202.00
203.00	Total (sum of lines 201 and 202)			203.00
204.00	Medicare swing-bed SNF discharges (see instructions)			204.00
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)			
205.00	Medicare swing-bed SNF target amount			205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)			206.00
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement			
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)			208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
	Comparision of PPS versus Cost Reimbursement			
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)			215.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-1328 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E-3 Part V Date/Time Prepared: 5/29/2024 2:18 pm

Title XVIII | Hospital | Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	6,648,662	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)	0	2.00
3.00	Organ acquisition	0	3.00
3.01	Cellular therapy acquisition cost (see instructions)	0	3.01
4.00	Subtotal (sum of lines 1 through 3.01)	6,648,662	4.00
5.00	Primary payer payments	272	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	6,714,877	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
7.00	Routine service charges	0	7.00
8.00	Ancillary service charges	0	8.00
9.00	Organ acquisition charges, net of revenue	0	9.00
10.00	Total reasonable charges	0	10.00
	Customary charges		
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	11.00
12.00	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	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13.00
14.00	Total customary charges (see instructions)	0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)	0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)	0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)	0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)	6,714,877	19.00
20.00	Deductibles (exclude professional component)	796,404	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	5,918,473	22.00
23.00	Coinsurance	16,800	23.00
24.00	Subtotal (line 22 minus line 23)	5,901,673	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	37,634	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	24,462	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	11,200	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	5,926,135	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	29.50
29.98	Recovery of accelerated depreciation.	0	29.98
29.99	Demonstration payment adjustment amount before sequestration	0	29.99
30.00	Subtotal (see instructions)	5,926,135	30.00
30.01	Sequestration adjustment (see instructions)	118,523	30.01
30.02	Demonstration payment adjustment amount after sequestration	0	30.02
30.03	Sequestration adjustment-PARHM		30.03
31.00	Interim payments	6,589,991	31.00
31.01	Interim payments-PARHM		31.01
32.00	Tentative settlement (for contractor use only)	0	32.00
32.01	Tentative settlement-PARHM (for contractor use only)		32.01
33.00	Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32)	-782,379	33.00
33.01	Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01)		33.01
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	488,826	34.00

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

Provider CCN: 15-1328 | Period: From 01/01/2023 To 12/31/2023 | Worksheet G | Date/Time Prepared: 5/29/2024 2:18 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	139,182,409	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	10,033,585	0	0	0	4.00
5.00	Other receivable	617,452	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	1,842,096	0	0	0	7.00
8.00	Prepaid expenses	198,445	0	0	0	8.00
9.00	Other current assets	0	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)	151,873,987	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	1,034,321	0	0	0	12.00
13.00	Land improvements	1,093,347	0	0	0	13.00
14.00	Accumulated depreciation	-1,082,052	0	0	0	14.00
15.00	Buildings	20,660,864	0	0	0	15.00
16.00	Accumulated depreciation	-14,296,295	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	266,329	0	0	0	21.00
22.00	Accumulated depreciation	-220,520	0	0	0	22.00
23.00	Major movable equipment	20,995,164	0	0	0	23.00
24.00	Accumulated depreciation	-14,512,297	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)	13,938,861	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	6,088,016	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	6,088,016	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	171,900,864	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	9,672,638	0	0	0	37.00
38.00	Salaries, wages, and fees payable	133,642	0	0	0	38.00
39.00	Payroll taxes payable	1,224,796	0	0	0	39.00
40.00	Notes and loans payable (short term)	65,337	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	3,683,910	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	14,780,323	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	114,929	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	114,929	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	14,895,252	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	157,005,612				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)	157,005,612	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	171,900,864	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 15-1328 | Period: From 01/01/2023 To 12/31/2023 | Worksheet G-1 | Date/Time Prepared: 5/29/2024 2:18 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		132,961,604		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		24,044,000				2.00
3.00	Total (sum of line 1 and line 2)		157,005,604		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00	ROUNDING	8		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)		157,005,612		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)		157,005,612		0		19.00

		Endowment Fund	Plant Fund		
		6.00	7.00	8.00	
1.00	Fund balances at beginning of period	0		0	1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)				2.00
3.00	Total (sum of line 1 and line 2)	0		0	3.00
4.00	Additions (credit adjustments) (specify)		0		4.00
5.00	ROUNDING		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: 15-1328 | Period: From 01/01/2023 To 12/31/2023 | Worksheet G-2 Parts I & II | Date/Time Prepared: 5/29/2024 2:18 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	11,955,741		11,955,741	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	33,587		33,587	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)	11,989,328		11,989,328	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	10,084,357		10,084,357	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	10,084,357		10,084,357	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	22,073,685		22,073,685	17.00
18.00	Ancillary services	26,218,106	219,699,246	245,917,352	18.00
19.00	Outpatient services	2,298,478	89,456,774	91,755,252	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	PHYSICIAN REVENUE	0	2,994,946	2,994,946	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	50,590,269	312,150,966	362,741,235	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		83,209,949		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		83,209,949		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 15-1328	Period: From 01/01/2023 To 12/31/2023	Worksheet G-3 Date/Time Prepared: 5/29/2024 2:18 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	362,741,235	1.00
2.00	Less contractual allowances and discounts on patients' accounts	264,026,307	2.00
3.00	Net patient revenues (line 1 minus line 2)	98,714,928	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	83,209,949	4.00
5.00	Net income from service to patients (line 3 minus line 4)	15,504,979	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	MISCELLANEOUS INCOME	8,539,021	24.00
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (sum of lines 6-24)	8,539,021	25.00
26.00	Total (line 5 plus line 25)	24,044,000	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)	24,044,000	29.00