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: 15-1306	Period: From 01/01/2023 To 12/31/2023	Worksheet S Parts I-III Date/Time Prepared: 5/29/2024 2:20 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 5/29/2024 Time: 2:20 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 IU HEALTH PAOLI HOSPITAL (15-1306) 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	-253,954	246,977	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	-6,193	0		0	5.00
6.00	SWING BED - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00	RURAL HEALTH CLINIC I	0		-5,581		0	10.00
11.00	FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0	11.00
200.00	TOTAL	0	-260,147	241,396	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: 15-1306 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I | Date/Time Prepared: 5/29/2024 2:20 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 642 WEST HOSPITAL ROAD	PO Box:			1.00
2.00	City: PAOLI	State: IN	Zip Code: 47454	County: ORANGE	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	IU HEALTH PAOLI HOSPITAL	151306	99915	1	07/01/2001	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	IUHP SWING BEDS	15Z306	99915		07/01/2001	N	O	N	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	IU HEALTH PAOLI FAMILY AND INTERNAL	158557	99915		12/07/2020	N	O	O	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	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: 15-1306 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I | Date/Time Prepared: 5/29/2024 2:20 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.				58.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1306 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I Date/Time Prepared: 5/29/2024 2:20 pm

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1306 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I Date/Time Prepared: 5/29/2024 2:20 pm

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1306 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I Date/Time Prepared: 5/29/2024 2:20 pm

				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: 15-1306 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I Date/Time Prepared: 5/29/2024 2:20 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.	Y		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

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		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	49,948	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.	Y		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	Contractor's Name: WISCONSIN PHYSICIAN SERVICES	Contractor's Number: 08101	141.00
142.00	Street: 340 WEST TENTH STREET	PO Box:		142.00
143.00	City: INDIANAPOLIS	State: IN	Zip Code: 46204	143.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1306 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I | Date/Time Prepared: 5/29/2024 2:20 pm

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

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

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

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

		1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act		
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.	Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)		168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)	N	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	35	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-1306 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part II | Date/Time Prepared: 5/29/2024 2:20 pm

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

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

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

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

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	N		N		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	04/01/2024	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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-1306 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part II Date/Time Prepared: 5/29/2024 2:20 pm

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

		1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)		
	Capital Related Cost		
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions	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.		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.	Y	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

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		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: 15-1306 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part I | Date/Time Prepared: 5/29/2024 2:20 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	24	8,760	37,920.00	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)		24	8,760	37,920.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	0	0	0.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		24	8,760	37,920.00	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	101.00				0	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	88.00				0	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		24				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

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	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)	653	42	1,580			1.00
2.00	HMO and other (see instructions)	391	541				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	15	0	15			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	49			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	668	42	1,644			7.00
8.00	INTENSIVE CARE UNIT	0	0	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		24	248			13.00
14.00	Total (see instructions)	668	66	1,892	0.00	133.79	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	0	0	0	0.00	0.00	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			33			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	600	0	10,760	0.00	2.68	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	136.47	27.00
28.00	Observation Bed Days		24	719			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: 15-1306 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part I | Date/Time Prepared: 5/29/2024 2:20 pm

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	172	11	455	1.00
2.00	HMO and other (see instructions)			98	110		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	172	11	455	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	0.00					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	0.00					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-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 15-1306 | Component CCN: 15-8557 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-8 | Date/Time Prepared: 5/29/2024 2:20 pm

		RHC I	Cost
		1.00	
	Clinic Address and Identification		
1.00	Street	560 W LONGEST ST	1.00
		City / State / ZIP Code	
		1.00 / 2.00 / 3.00	
2.00	City, State, ZIP Code, County	PAOLI / IN / 47454	2.00
		1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban	0	3.00
		Grant Award / Date	
		1.00 / 2.00	
	Source of Federal Funds		
4.00	Community Health Center (Section 330(d), PHS Act)		4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)		5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)		6.00
7.00	Appalachian Regional Commission		7.00
8.00	Look-Alikes		8.00
9.00	OTHER (SPECIFY)		9.00
		1.00 / 2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)	N	0 10.00
		Sunday from / Sunday to / Monday from / Monday to / Tuesday from	
		1.00 / 2.00 / 3.00 / 4.00 / 5.00	
	Facility hours of operations (1)		
11.00	CLINIC		07:00 11.00
		1.00 / 2.00	
12.00	Have you received an approval for an exception to the productivity standard?	N	12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.	N	0 13.00
13.01	If line 13, column 1, is "Y", are you reporting multiple consolidated RHCs (as defined in CMS Pub. 100-02, chapter 13, section 80.2)? Enter "Y" for yes or "N" for no. If yes, enter in column 2 the number of consolidated RHC groupings and complete a separate Worksheet S-8 for each consolidated RHC grouping. Consolidated RHC groupings are comprised exclusively of grandfathered consolidated RHCs in the grouping or comprised exclusively of new consolidated RHCs in the grouping.	N	0 13.01
		Provider name / CCN	
		1.00 / 2.00	
14.00	RHC/FQHC name, CCN		14.00

		Y/N	V	XVIII	XIX	Total Visits	
		1.00	2.00	3.00	4.00	5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)						15.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 15-1306
Component CCN: 15-8557

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

Worksheet S-8

Date/Time Prepared:
5/29/2024 2:20 pm

RHC I | Cost

			County				
			4.00				
2.00	City, State, ZIP Code, County		ORANGE				2.00
		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	CLINIC	19:00	07:00	19:00	07:00	19:00	11.00
		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	CLINIC	07:00	19:00				11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 15-1306	Period: From 01/01/2023 To 12/31/2023	Worksheet S-10 Parts I & II Date/Time Prepared: 5/29/2024 2:20 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)	0.343462	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	6,729,556	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?	Y	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	26,662,169	6.00
7.00	Medicaid cost (line 1 times line 6)	9,157,442	7.00
8.00	Difference between net revenue and costs for Medicaid program (see instructions)	2,427,886	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	0	9.00
10.00	Stand-alone CHIP charges	0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (see instructions)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (see instructions)	0	16.00
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	2,427,886	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)	1,247,318	80,173	1,327,491	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	428,406	63,966	492,372	21.00
22.00	Payments received from patients for amounts previously written off as charity care	1,057	0	1,057	22.00
23.00	Cost of charity care (see instructions)	427,349	63,966	491,315	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)	24,686	25.01
26.00	Bad debt amount (see instructions)	2,156,997	26.00
27.00	Medicare reimbursable bad debts (see instructions)	345,361	27.00
27.01	Medicare allowable bad debts (see instructions)	531,323	27.01
28.00	Non-Medicare bad debt amount (see instructions)	1,625,674	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)	744,319	29.00
30.00	Cost of uncompensated care (line 23, col. 3, plus line 29)	1,235,634	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	3,663,520	31.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 15-1306	Period: From 01/01/2023 To 12/31/2023	Worksheet S-10 Parts I & II Date/Time Prepared: 5/29/2024 2:20 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: 15-1306 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A | Date/Time Prepared: 5/29/2024 2:20 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	519,678	519,678	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	940,149	940,149	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	53,582	53,582	2,078,252	2,131,834	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	344,902	8,130,869	8,475,771	-202,857	8,272,914	5.00
7.00	00700	OPERATION OF PLANT	464,037	1,635,029	2,099,066	-890,221	1,208,845	7.00
7.01	00701	UTILITIES	0	0	0	465,086	465,086	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	73,923	73,923	-4,238	69,685	8.00
9.00	00900	HOUSEKEEPING	252,660	349,578	602,238	-91,718	510,520	9.00
10.00	01000	DIETARY	180,560	274,951	455,511	-209,108	246,403	10.00
11.00	01100	CAFETERIA	0	0	0	170,562	170,562	11.00
13.00	01300	NURSING ADMINISTRATION	970,394	402,981	1,373,375	-281,411	1,091,964	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	26,448	26,448	162,385	188,833	14.00
15.00	01500	PHARMACY	371,785	2,645,231	3,017,016	-2,386,942	630,074	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	337,345	310,261	647,606	-37,098	610,508	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,673,189	1,896,305	3,569,494	-635,493	2,934,001	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	354,652	21,727	376,379	-322,574	53,805	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	501,418	601,327	1,102,745	-349,887	752,858	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	52,731	641	53,372	365,819	419,191	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	983,478	713,625	1,697,103	-499,095	1,198,008	54.00
60.00	06000	LABORATORY	0	2,553,052	2,553,052	1,390	2,554,442	60.00
64.00	06400	INTRAVENOUS THERAPY	84,464	60,256	144,720	-36,531	108,189	64.00
65.00	06500	RESPIRATORY THERAPY	484,132	293,262	777,394	-125,883	651,511	65.00
66.00	06600	PHYSICAL THERAPY	697,607	334,793	1,032,400	-532,936	499,464	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	280,312	280,312	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	93,581	93,581	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	117,180	117,180	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	15,245	15,245	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	2,402,805	2,402,805	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
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						
88.00	08800	RURAL HEALTH CLINIC	903,920	562,454	1,466,374	-392,686	1,073,688	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	73,571	14,197	87,768	-2,995	84,773	90.00
90.01	09001	VISITING SPECIALTY CLINIC	311,045	174,830	485,875	-120,852	365,023	90.01
90.02	09002	PAOLI PRIMARY CARE CLINIC	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	1,383,597	2,195,224	3,578,821	-489,655	3,089,166	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	10,425,487	23,324,546	33,750,033	264	33,750,297	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	VISITING SPECIALTY CLINIC	0	0	0	0	0	190.01
190.02	19002	OUTREACH	0	512	512	0	512	190.02
190.03	19003	FOUNDATION	0	0	0	0	0	190.03
190.04	19004	SPRING VALLEY FAMILY PRACTICE	0	0	0	0	0	190.04
190.05	19005	PAOLI FAMILY PRACTICE	0	6,003	6,003	-264	5,739	190.05
190.06	19006	OTHER PROPERTY	0	0	0	0	0	190.06
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		TOTAL (SUM OF LINES 118 through 199)	10,425,487	23,331,061	33,756,548	0	33,756,548	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1306 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A | Date/Time Prepared: 5/29/2024 2:20 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	0	519,678		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	940,149		2.00
3.00	00300	OTHER CAP REL COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-252,156	1,879,678		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-749,401	7,523,513		5.00
7.00	00700	OPERATION OF PLANT	99,469	1,308,314		7.00
7.01	00701	UTILITIES	0	465,086		7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	69,685		8.00
9.00	00900	HOUSEKEEPING	-182	510,338		9.00
10.00	01000	DIETARY	0	246,403		10.00
11.00	01100	CAFETERIA	0	170,562		11.00
13.00	01300	NURSING ADMINISTRATION	77,747	1,169,711		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	188,833		14.00
15.00	01500	PHARMACY	-78,359	551,715		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0		16.00
17.00	01700	SOCIAL SERVICE	0	0		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	-304,516	305,992		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-869,592	2,064,409		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0		31.00
43.00	04300	NURSERY	0	53,805		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	752,858		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	419,191		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	35,317	1,233,325		54.00
60.00	06000	LABORATORY	0	2,554,442		60.00
64.00	06400	INTRAVENOUS THERAPY	0	108,189		64.00
65.00	06500	RESPIRATORY THERAPY	22,561	674,072		65.00
66.00	06600	PHYSICAL THERAPY	118,647	618,111		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	280,312		67.00
68.00	06800	SPEECH PATHOLOGY	0	93,581		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	117,180		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	15,245		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,402,805		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0		75.00
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0		77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0		78.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	36,855	1,110,543		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0		89.00
90.00	09000	CLINIC	-5,531	79,242		90.00
90.01	09001	VISITING SPECIALTY CLINIC	0	365,023		90.01
90.02	09002	PAOLI PRIMARY CARE CLINIC	0	0		90.02
91.00	09100	EMERGENCY	1,035,908	4,125,074		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	0		95.00
101.00	10100	HOME HEALTH AGENCY	0	0		101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0		102.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-833,233	32,917,064		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
190.01	19001	VISITING SPECIALTY CLINIC	0	0		190.01
190.02	19002	OUTREACH	0	512		190.02
190.03	19003	FOUNDATION	0	0		190.03
190.04	19004	SPRING VALLEY FAMILY PRACTICE	0	0		190.04
190.05	19005	PAOLI FAMILY PRACTICE	0	5,739		190.05
190.06	19006	OTHER PROPERTY	0	0		190.06
191.00	19100	RESEARCH	0	0		191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		192.00
193.00	19300	NONPAID WORKERS	0	0		193.00
200.00		TOTAL (SUM OF LINES 118 through 199)	-833,233	32,923,315		200.00

RECLASSIFICATIONS | Provider CCN: 15-1306 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-6 | Date/Time Prepared: 5/29/2024 2:20 pm

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - EMPLOYEE BENEFITS				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	2,079,282	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
	0		0	2,079,282	
	B - BILLABLE DRUGS				
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	2,402,805	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
	0		0	2,402,805	
	C - BILLABLE SUPPLIES				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	117,180	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
	0		0	117,180	
	D - IMPLANT SUPPLIES				
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	15,245	1.00
	0		0	15,245	
	E - NON-BILLABLE DRUGS				
1.00	PHARMACY	15.00	0	94,532	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
	0		0	94,532	
	F - NON-BILLABLE MED SUPPLIES				
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	176,285	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	8,257	2.00
3.00	OPERATION OF PLANT	7.00	0	177	3.00
4.00	HOUSEKEEPING	9.00	0	44	4.00
5.00	DIETARY	10.00	0	17	5.00

RECLASSIFICATIONS | Provider CCN: 15-1306 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-6 | Date/Time Prepared: 5/29/2024 2:20 pm

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
6.00	PHYSICAL THERAPY	66.00	0	73	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	184,853	
	G - CAPITAL RELATED COSTS				
1.00	CAP REL COSTS-BLDG & FIXT	1.00		382,815	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00		938,091	2.00
3.00	CAP REL COSTS-BLDG & FIXT	1.00		21,865	3.00
4.00	CAP REL COSTS-MVBLE EQUIP	2.00		2,121	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
	0		0	1,344,892	
	H - LEASE EXPENSE				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	118,791	1.00
	0		0	118,791	
	J - UTILITIES				
1.00	UTILITIES	7.01	0	465,086	1.00
2.00		0.00	0	0	2.00
	0		0	465,086	
	K - LAUNDRY				
1.00	HOUSEKEEPING	9.00	0	4,238	1.00
	0		0	4,238	
	L - OBSTETRICS				
1.00	ADULTS & PEDIATRICS	30.00	126,506	0	1.00
2.00	NURSERY	43.00	0	9,776	2.00
3.00	DELIVERY ROOM & LABOR ROOM	52.00	196,195	170,060	3.00
	0		322,701	179,836	
	M - CAFETERIA				
1.00	CAFETERIA	11.00	75,651	94,911	1.00
	0		75,651	94,911	
	N - OT AND ST				
1.00	OCCUPATIONAL THERAPY	67.00	223,903	56,409	1.00
2.00	SPEECH PATHOLOGY	68.00	74,749	18,832	2.00
	0		298,652	75,241	
	Q - BLOOD STORAGE				
1.00	LABORATORY	60.00	0	1,390	1.00
	0		0	1,390	
500.00	Grand Total: Increases		697,004	7,178,282	500.00

RECLASSIFICATIONS | Provider CCN: 15-1306 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-6 | Date/Time Prepared: 5/29/2024 2:20 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - EMPLOYEE BENEFITS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	47,996	0		1.00
2.00	OPERATION OF PLANT	7.00	0	83,371	0		2.00
3.00	HOUSEKEEPING	9.00	0	86,216	0		3.00
4.00	DIETARY	10.00	0	32,890	0		4.00
5.00	NURSING ADMINISTRATION	13.00	0	179,621	0		5.00
6.00	PHARMACY	15.00	0	120,975	0		6.00
7.00	NONPHYSICIAN ANESTHETISTS	19.00	0	20,470	0		7.00
8.00	ADULTS & PEDIATRICS	30.00	0	421,385	0		8.00
9.00	OPERATING ROOM	50.00	0	121,759	0		9.00
10.00	DELIVERY ROOM & LABOR ROOM	52.00	0	15	0		10.00
11.00	RADIOLOGY-DIAGNOSTIC	54.00	0	155,634	0		11.00
12.00	INTRAVENOUS THERAPY	64.00	0	24,154	0		12.00
13.00	RESPIRATORY THERAPY	65.00	0	84,852	0		13.00
14.00	PHYSICAL THERAPY	66.00	0	149,940	0		14.00
15.00	RURAL HEALTH CLINIC	88.00	0	175,171	0		15.00
16.00	CLINIC	90.00	0	2,995	0		16.00
17.00	VISITING SPECIALTY CLINIC	90.01	0	91,979	0		17.00
18.00	EMERGENCY	91.00	0	279,859	0		18.00
	0		0	2,079,282			
	B - BILLABLE DRUGS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	227	0		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	9	0		2.00
3.00	NURSING ADMINISTRATION	13.00	0	170	0		3.00
4.00	CENTRAL SERVICES & SUPPLY	14.00	0	43	0		4.00
5.00	PHARMACY	15.00	0	2,299,735	0		5.00
6.00	ADULTS & PEDIATRICS	30.00	0	7,137	0		6.00
7.00	NURSERY	43.00	0	758	0		7.00
8.00	OPERATING ROOM	50.00	0	3,596	0		8.00
9.00	RADIOLOGY-DIAGNOSTIC	54.00	0	66,249	0		9.00
10.00	INTRAVENOUS THERAPY	64.00	0	237	0		10.00
11.00	RESPIRATORY THERAPY	65.00	0	210	0		11.00
12.00	PHYSICAL THERAPY	66.00	0	37	0		12.00
13.00	VISITING SPECIALTY CLINIC	90.01	0	13,679	0		13.00
14.00	EMERGENCY	91.00	0	10,718	0		14.00
	0		0	2,402,805			
	C - BILLABLE SUPPLIES						
1.00	NURSING ADMINISTRATION	13.00	0	3	0		1.00
2.00	CENTRAL SERVICES & SUPPLY	14.00	0	13,131	0		2.00
3.00	PHARMACY	15.00	0	86	0		3.00
4.00	ADULTS & PEDIATRICS	30.00	0	6,407	0		4.00
5.00	NURSERY	43.00	0	1,999	0		5.00
6.00	OPERATING ROOM	50.00	0	58,911	0		6.00
7.00	RADIOLOGY-DIAGNOSTIC	54.00	0	842	0		7.00
8.00	INTRAVENOUS THERAPY	64.00	0	3,670	0		8.00
9.00	RESPIRATORY THERAPY	65.00	0	143	0		9.00
10.00	PHYSICAL THERAPY	66.00	0	2,783	0		10.00
11.00	VISITING SPECIALTY CLINIC	90.01	0	7,970	0		11.00
12.00	EMERGENCY	91.00	0	21,235	0		12.00
	0		0	117,180			
	D - IMPLANT SUPPLIES						
1.00	OPERATING ROOM	50.00	0	15,245	0		1.00
	0		0	15,245			
	E - NON-BILLABLE DRUGS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	250	0		1.00
2.00	HOUSEKEEPING	9.00	0	174	0		2.00
3.00	NURSING ADMINISTRATION	13.00	0	904	0		3.00
4.00	CENTRAL SERVICES & SUPPLY	14.00	0	22	0		4.00
5.00	ADULTS & PEDIATRICS	30.00	0	18,957	0		5.00
6.00	NURSERY	43.00	0	97	0		6.00
7.00	OPERATING ROOM	50.00	0	6,106	0		7.00
8.00	RADIOLOGY-DIAGNOSTIC	54.00	0	5,471	0		8.00
9.00	INTRAVENOUS THERAPY	64.00	0	5,311	0		9.00
10.00	PHYSICAL THERAPY	66.00	0	19	0		10.00
11.00	EMERGENCY	91.00	0	57,221	0		11.00
	0		0	94,532			
	F - NON-BILLABLE MED SUPPLIES						
1.00	NURSING ADMINISTRATION	13.00	0	762	0		1.00
2.00	PHARMACY	15.00	0	3,620	0		2.00
3.00	NONPHYSICIAN ANESTHETISTS	19.00	0	2,103	0		3.00
4.00	ADULTS & PEDIATRICS	30.00	0	59,368	0		4.00
5.00	NURSERY	43.00	0	6,198	0		5.00
6.00	OPERATING ROOM	50.00	0	21,628	0		6.00
7.00	DELIVERY ROOM & LABOR ROOM	52.00	0	421	0		7.00

RECLASSIFICATIONS | Provider CCN: 15-1306 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-6 | Date/Time Prepared: 5/29/2024 2:20 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
8.00	RADIOLOGY-DIAGNOSTIC	54.00	0	1,236	0		8.00
9.00	INTRAVENOUS THERAPY	64.00	0	3,159	0		9.00
10.00	RESPIRATORY THERAPY	65.00	0	11,087	0		10.00
11.00	RURAL HEALTH CLINIC	88.00	0	2,198	0		11.00
12.00	VISITING SPECIALTY CLINIC	90.01	0	921	0		12.00
13.00	EMERGENCY	91.00	0	72,152	0		13.00
	0		0	184,853			
	G - CAPITAL RELATED COSTS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00		803	9		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00		44,068	9		2.00
3.00	OPERATION OF PLANT	7.00		401,291	12		3.00
4.00	HOUSEKEEPING	9.00		9,610	12		4.00
5.00	DIETARY	10.00		5,673	0		5.00
6.00	NURSING ADMINISTRATION	13.00		99,951	0		6.00
7.00	CENTRAL SERVICES & SUPPLY	14.00		704	0		7.00
8.00	PHARMACY	15.00		57,058	0		8.00
9.00	NONPHYSICIAN ANESTHETISTS	19.00		14,525	0		9.00
10.00	ADULTS & PEDIATRICS	30.00		68,909	0		10.00
11.00	NURSERY	43.00		597	0		11.00
12.00	OPERATING ROOM	50.00		122,642	0		12.00
13.00	RADIOLOGY-DIAGNOSTIC	54.00		269,663	0		13.00
14.00	RESPIRATORY THERAPY	65.00		29,591	0		14.00
15.00	PHYSICAL THERAPY	66.00		6,337	0		15.00
16.00	RURAL HEALTH CLINIC	88.00		154,577	0		16.00
17.00	VISITING SPECIALTY CLINIC	90.01		6,303	0		17.00
18.00	EMERGENCY	91.00		48,470	0		18.00
19.00	PAOLI FAMILY PRACTICE	190.05		264	0		19.00
20.00	CAP REL COSTS-MVBLE EQUIP	2.00		63	10		20.00
21.00	CAP REL COSTS-BLDG & FIXT	1.00		3,793	13		21.00
	0		0	1,344,892			
	H - LEASE EXPENSE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	118,791	10		1.00
	0		0	118,791			
	J - UTILITIES						
1.00	OPERATION OF PLANT	7.00	0	404,346			1.00
2.00	RURAL HEALTH CLINIC	88.00	0	60,740			2.00
	0		0	465,086			
	K - LAUNDRY						
1.00	LAUNDRY & LINEN SERVICE	8.00	0	4,238	0		1.00
	0		0	4,238			
	L - OBSTETRICS						
1.00	ADULTS & PEDIATRICS	30.00	0	179,836	0		1.00
2.00	NURSERY	43.00	322,701	0	0		2.00
3.00		0.00	0	0	0		3.00
	0		322,701	179,836			
	M - CAFETERIA						
1.00	DIETARY	10.00	75,651	94,911	0		1.00
	0		75,651	94,911			
	N - OT AND ST						
1.00	PHYSICAL THERAPY	66.00	298,652	75,241	0		1.00
2.00		0.00	0	0	0		2.00
	0		298,652	75,241			
	Q - BLOOD STORAGE						
1.00	OPERATION OF PLANT	7.00	0	1,390	0		1.00
	0		0	1,390			
500.00	Grand Total: Decreases		697,004	7,178,282			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1306 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-7 Part I | Date/Time Prepared: 5/29/2024 2:20 pm

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	183,505	0	0	0	0	1.00
2.00	Land Improvements	625,604	0	0	0	0	2.00
3.00	Buildings and Fixtures	8,531,552	0	0	0	0	3.00
4.00	Building Improvements	3,527,295	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	13,081,025	459,699	0	459,699	238,035	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	25,948,981	459,699	0	459,699	238,035	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	25,948,981	459,699	0	459,699	238,035	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	183,505	0	1.00
2.00	Land Improvements	625,604	323,564	2.00
3.00	Buildings and Fixtures	8,531,552	2,690,976	3.00
4.00	Building Improvements	3,527,295	791,602	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	13,302,689	6,087,230	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	26,170,645	9,893,372	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	26,170,645	9,893,372	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1306 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-7 Part II | Date/Time Prepared: 5/29/2024 2:20 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: 15-1306 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-7 Part III Date/Time Prepared: 5/29/2024 2:20 pm

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	12,867,956	0	12,867,956	0.491694	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	13,302,689	0	13,302,689	0.508306	0	2.00
3.00	Total (sum of lines 1-2)	26,170,645	0	26,170,645	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	1,457,014	-955,408	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	938,091	-63	2.00
3.00	Total (sum of lines 1-2)	0	0	0	2,395,105	-955,471	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	21,865	-3,793	0	519,678	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	2,121	0	0	940,149	2.00
3.00	Total (sum of lines 1-2)	0	23,986	-3,793	0	1,459,827	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1306 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-8 | Date/Time Prepared: 5/29/2024 2:20 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-1,074,199	CAP REL COSTS-BLDG & FIXT	1.00	10	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	-871,499			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	5,020,099			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	NONPHYSICIAN ANESTHETISTS	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	-120	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1306 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-8 | Date/Time Prepared: 5/29/2024 2:20 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.01	MISCELLANEOUS INCOME	B	336	ADMINISTRATIVE & GENERAL	5.00	0	33.01
33.02	MISCELLANEOUS INCOME	B	-182	HOUSEKEEPING	9.00	0	33.02
33.03	MISCELLANEOUS INCOME	B	-136,481	PHARMACY	15.00	0	33.03
33.04	MISCELLANEOUS INCOME	B	-4,508	RURAL HEALTH CLINIC	88.00	0	33.04
33.05	HAF	A	-1,423,620	ADMINISTRATIVE & GENERAL	5.00	0	33.05
33.06	BENEFITS	A	-2,079,282	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.06
33.07	CRNA	A	-304,516	NONPHYSICIAN ANESTHETISTS	19.00	0	33.07
33.08	MARKETING	A	-189	ADULTS & PEDIATRICS	30.00	0	33.08
33.09	MARKETING	A	-325	RESPIRATORY THERAPY	65.00	0	33.09
33.10	MARKETING	A	-67	RURAL HEALTH CLINIC	88.00	0	33.10
33.11	CLINIC START UP AMORTIZIATION	A	41,430	RURAL HEALTH CLINIC	88.00	0	33.11
33.12	UNWONTED EXPENSE	A	-30	NURSING ADMINISTRATION	13.00	0	33.12
33.13	UNWONTED EXPENSE	A	-80	EMERGENCY	91.00	0	33.13
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-833,233				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: 15-1306 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-8-1 | Date/Time Prepared: 5/29/2024 2:20 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 ALLOCATION	1,074,199	0	1.00
2.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE ALLOCATION	1,819,670	0	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE ALLOCATION	5,030,337	5,270,654	3.00
3.01	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE ALLOCATION	212,151	0	3.01
3.02	4.00	EMPLOYEE BENEFITS DEPARTMENT	RELATED PARTY	7,576	0	3.02
3.03	5.00	ADMINISTRATIVE & GENERAL	RELATED PARTY	1,240,277	538,108	3.03
3.04	7.00	OPERATION OF PLANT	RELATED PARTY	99,469	0	3.04
3.05	13.00	NURSING ADMINISTRATION	RELATED PARTY	102,499	24,722	3.05
3.06	15.00	PHARMACY	RELATED PARTY	192,316	134,194	3.06
3.07	54.00	RADIOLOGY-DIAGNOSTIC	RELATED PARTY	53,095	16,056	3.07
3.08	65.00	RESPIRATORY THERAPY	RELATED PARTY	22,886	0	3.08
3.09	66.00	PHYSICAL THERAPY	RELATED PARTY	229,415	110,768	3.09
3.10	90.00	CLINIC	RELATED PARTY	0	5,531	3.10
3.11	91.00	EMERGENCY	SIP ER ALLOCATION	2,279,544	1,243,302	3.11
3.12	4.00	EMPLOYEE BENEFITS DEPARTMENT	SHARED EMPLOYEES	1,512	1,512	3.12
3.13	5.00	ADMINISTRATIVE & GENERAL	SHARED EMPLOYEES	17,872	17,872	3.13
3.14	10.00	DIETARY	SHARED EMPLOYEES	4,544	4,544	3.14
3.15	15.00	PHARMACY	SHARED EMPLOYEES	-41	-41	3.15
3.16	30.00	ADULTS & PEDIATRICS	SHARED EMPLOYEES	55,438	55,438	3.16
3.17	54.00	RADIOLOGY-DIAGNOSTIC	SHARED EMPLOYEES	1,722	1,722	3.17
3.18	60.00	LABORATORY	SHARED EMPLOYEES	2,267,689	2,267,689	3.18
3.19	65.00	RESPIRATORY THERAPY	SHARED EMPLOYEES	304	304	3.19
4.00	88.00	RURAL HEALTH CLINIC	SHARED EMPLOYEES	4,052	4,052	4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			14,716,526	9,696,427	5.00

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

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

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

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

6.00	B		0.00	IU HEALTH BLOOM	0.00	6.00
7.00	B		0.00	IU HEALTH	100.00	7.00
8.00	C		0.00	IUH SIP	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: 15-1306 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-8-1 | Date/Time Prepared: 5/29/2024 2:20 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	1,074,199	9		1.00
2.00	1,819,670	9		2.00
3.00	-240,317	0		3.00
3.01	212,151	0		3.01
3.02	7,576	0		3.02
3.03	702,169	0		3.03
3.04	99,469	0		3.04
3.05	77,777	0		3.05
3.06	58,122	0		3.06
3.07	37,039	0		3.07
3.08	22,886	0		3.08
3.09	118,647	0		3.09
3.10	-5,531	0		3.10
3.11	1,036,242	0		3.11
3.12	0	0		3.12
3.13	0	0		3.13
3.14	0	0		3.14
3.15	0	0		3.15
3.16	0	0		3.16
3.17	0	0		3.17
3.18	0	0		3.18
3.19	0	0		3.19
4.00	0	0		4.00
5.00	5,020,099			5.00

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

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

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

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

6.00	HOSPITAL		6.00
7.00	HOME OFFICE		7.00
8.00	PHYSICIAN GROUP		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: 15-1306 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-8-2 | Date/Time Prepared: 5/29/2024 2:20 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	120	120	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	869,403	869,403	0	0	0	2.00
3.00	54.00	RADIOLOGY-DIAGNOSTIC	1,722	1,722	0	0	0	3.00
4.00	91.00	EMERGENCY	1,200,556	254	1,200,302	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			2,071,801	871,499	1,200,302		0	200.00

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

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	120		1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	869,403		2.00
3.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	1,722		3.00
4.00	91.00	EMERGENCY	0	0	0	254		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	871,499		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1306 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I | Date/Time Prepared: 5/29/2024 2:20 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	519,678	519,678				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	940,149		940,149			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,879,678	5,484	10,505	1,895,667		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	7,523,513	29,218	55,962	62,714	7,671,407	5.00
7.00	00700	OPERATION OF PLANT	1,308,314	35,662	68,304	84,376	1,496,656	7.00
7.01	00701	UTILITIES	465,086	0	0	0	465,086	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	69,685	2,482	4,753	0	76,920	8.00
9.00	00900	HOUSEKEEPING	510,338	7,329	14,038	45,941	577,646	9.00
10.00	01000	DIETARY	246,403	14,485	27,743	19,076	307,707	10.00
11.00	01100	CAFETERIA	170,562	8,314	15,923	13,756	208,555	11.00
13.00	01300	NURSING ADMINISTRATION	1,169,711	15,742	30,152	176,447	1,392,052	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	188,833	17,306	33,146	0	239,285	14.00
15.00	01500	PHARMACY	551,715	9,670	18,522	67,602	647,509	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	6,229	11,931	0	18,160	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	305,992	0	0	61,339	367,331	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,064,409	58,903	112,827	327,238	2,563,377	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	53,805	2,068	3,961	5,810	65,644	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	752,858	49,857	95,493	91,173	989,381	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	419,191	4,856	9,301	45,262	478,610	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,233,325	49,518	94,844	178,826	1,556,513	54.00
60.00	06000	LABORATORY	2,554,442	15,494	29,676	0	2,599,612	60.00
64.00	06400	INTRAVENOUS THERAPY	108,189	3,723	7,130	15,358	134,400	64.00
65.00	06500	RESPIRATORY THERAPY	674,072	4,657	8,920	88,030	775,679	65.00
66.00	06600	PHYSICAL THERAPY	618,111	26,099	49,989	72,542	766,741	66.00
67.00	06700	OCCUPATIONAL THERAPY	280,312	14,650	28,060	40,712	363,734	67.00
68.00	06800	SPEECH PATHOLOGY	93,581	4,889	9,364	13,592	121,426	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	117,180	0	0	0	117,180	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	15,245	0	0	0	15,245	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,402,805	0	0	0	2,402,805	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
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						
88.00	08800	RURAL HEALTH CLINIC	1,110,543	41,345	78,714	164,360	1,394,962	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	79,242	314	602	13,377	93,535	90.00
90.01	09001	VISITING SPECIALTY CLINIC	365,023	28,597	54,773	56,557	504,950	90.01
90.02	09002	PAOLI PRIMARY CARE CLINIC	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	4,125,074	34,206	65,516	251,579	4,476,375	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	32,917,064	491,097	940,149	1,895,667	32,888,483	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	VISITING SPECIALTY CLINIC	0	0	0	0	0	190.01
190.02	19002	OUTREACH	512	5,154	0	0	5,666	190.02
190.03	19003	FOUNDATION	0	0	0	0	0	190.03
190.04	19004	SPRING VALLEY FAMILY PRACTICE	0	0	0	0	0	190.04
190.05	19005	PAOLI FAMILY PRACTICE	5,739	0	0	0	5,739	190.05
190.06	19006	OTHER PROPERTY	0	23,427	0	0	23,427	190.06
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
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)	32,923,315	519,678	940,149	1,895,667	32,923,315	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1306 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I | Date/Time Prepared: 5/29/2024 2:20 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	UTILITIES	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	7.00	7.01	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	7,671,407					5.00
7.00	00700	OPERATION OF PLANT	454,677	1,951,333				7.00
7.01	00701	UTILITIES	141,291	0	606,377			7.01
8.00	00800	LAUNDRY & LINEN SERVICE	23,368	13,056	3,390	116,734		8.00
9.00	00900	HOUSEKEEPING	175,486	38,558	10,012	0	801,702	9.00
10.00	01000	DIETARY	93,480	76,203	19,786	0	29,863	10.00
11.00	01100	CAFETERIA	63,358	43,737	11,356	0	17,140	11.00
13.00	01300	NURSING ADMINISTRATION	422,898	53,442	21,503	0	32,456	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	72,694	91,043	23,639	0	0	14.00
15.00	01500	PHARMACY	196,710	50,874	13,209	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	5,517	32,770	8,509	0	12,842	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	111,593	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	778,741	309,904	80,466	100,897	121,450	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	19,942	10,880	2,825	15,837	4,264	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	300,569	262,293	68,103	0	102,790	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	145,399	25,546	6,633	0	10,011	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	472,861	260,508	67,640	0	102,091	54.00
60.00	06000	LABORATORY	789,749	81,512	21,164	0	31,944	60.00
64.00	06400	INTRAVENOUS THERAPY	40,830	19,584	5,085	0	7,675	64.00
65.00	06500	RESPIRATORY THERAPY	235,647	24,502	6,362	0	9,602	65.00
66.00	06600	PHYSICAL THERAPY	232,932	4,961	35,651	0	53,808	66.00
67.00	06700	OCCUPATIONAL THERAPY	110,501	2,785	20,012	0	30,204	67.00
68.00	06800	SPEECH PATHOLOGY	36,889	914	6,678	0	10,079	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	35,599	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,631	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	729,960	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
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						
88.00	08800	RURAL HEALTH CLINIC	423,782	216,206	56,137	0	84,729	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	28,415	1,654	429	0	648	90.00
90.01	09001	VISITING SPECIALTY CLINIC	153,401	150,447	39,063	0	58,959	90.01
90.02	09002	PAOLI PRIMARY CARE CLINIC	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	1,359,906	179,954	46,724	0	70,522	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	7,660,826	1,951,333	574,376	116,734	791,077	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	VISITING SPECIALTY CLINIC	0	0	0	0	0	190.01
190.02	19002	OUTREACH	1,721	0	0	0	10,625	190.02
190.03	19003	FOUNDATION	0	0	0	0	0	190.03
190.04	19004	SPRING VALLEY FAMILY PRACTICE	0	0	0	0	0	190.04
190.05	19005	PAOLI FAMILY PRACTICE	1,743	0	0	0	0	190.05
190.06	19006	OTHER PROPERTY	7,117	0	32,001	0	0	190.06
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
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)	7,671,407	1,951,333	606,377	116,734	801,702	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1306 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I | Date/Time Prepared: 5/29/2024 2:20 pm

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	UTILITIES						7.01
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	527,039					10.00
11.00	01100	CAFETERIA	0	344,146				11.00
13.00	01300	NURSING ADMINISTRATION	0	26,145	1,948,496			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	426,661		14.00
15.00	01500	PHARMACY	0	13,174	0	5,565	927,041	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	6,009	0	2,729	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	527,039	59,149	653,871	72,424	7,041	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	0	1,046	14,663	8,726	36	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	16,037	222,704	46,979	2,268	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	8,149	114,215	610	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	35,071	38,835	5,823	2,032	54.00
60.00	06000	LABORATORY	0	32,421	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	3,074	52,975	3,943	1,973	64.00
65.00	06500	RESPIRATORY THERAPY	0	16,712	0	22,829	0	65.00
66.00	06600	PHYSICAL THERAPY	0	16,228	0	339	4	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	5,364	0	190	2	67.00
68.00	06800	SPEECH PATHOLOGY	0	2,927	0	63	1	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	139,813	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	18,190	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	892,432	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
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						
88.00	08800	RURAL HEALTH CLINIC	0	34,491	131,242	4,608	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	1,369	0	0	0	90.00
90.01	09001	VISITING SPECIALTY CLINIC	0	16,448	113,966	1,876	0	90.01
90.02	09002	PAOLI PRIMARY CARE CLINIC	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	0	50,332	606,025	91,954	21,252	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	527,039	344,146	1,948,496	426,661	927,041	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	VISITING SPECIALTY CLINIC	0	0	0	0	0	190.01
190.02	19002	OUTREACH	0	0	0	0	0	190.02
190.03	19003	FOUNDATION	0	0	0	0	0	190.03
190.04	19004	SPRING VALLEY FAMILY PRACTICE	0	0	0	0	0	190.04
190.05	19005	PAOLI FAMILY PRACTICE	0	0	0	0	0	190.05
190.06	19006	OTHER PROPERTY	0	0	0	0	0	190.06
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
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)	527,039	344,146	1,948,496	426,661	927,041	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1306 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I | Date/Time Prepared: 5/29/2024 2:20 pm

		Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			16.00	17.00	19.00	24.00	25.00	
		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
7.01	00701	UTILITIES						7.01
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	77,798					16.00
17.00	01700	SOCIAL SERVICE	0	0				17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	487,662			19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,189	0	0	5,280,548	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	291	0	0	144,154	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,859	0	487,662	2,505,645	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,087	0	0	790,260	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	14,333	0	0	2,555,707	0	54.00
60.00	06000	LABORATORY	8,091	0	0	3,564,493	0	60.00
64.00	06400	INTRAVENOUS THERAPY	1,557	0	0	271,096	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,400	0	0	1,092,733	0	65.00
66.00	06600	PHYSICAL THERAPY	1,584	0	0	1,112,248	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	858	0	0	533,650	0	67.00
68.00	06800	SPEECH PATHOLOGY	199	0	0	179,176	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	159	0	0	292,751	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	88	0	0	38,154	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	10,663	0	0	4,035,860	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
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						
88.00	08800	RURAL HEALTH CLINIC	1,475	0	0	2,347,632	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	68	0	0	126,118	0	90.00
90.01	09001	VISITING SPECIALTY CLINIC	1,263	0	0	1,040,373	0	90.01
90.02	09002	PAOLI PRIMARY CARE CLINIC	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	21,634	0	0	6,924,678	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	77,798	0	487,662	32,835,276	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	VISITING SPECIALTY CLINIC	0	0	0	0	0	190.01
190.02	19002	OUTREACH	0	0	0	18,012	0	190.02
190.03	19003	FOUNDATION	0	0	0	0	0	190.03
190.04	19004	SPRING VALLEY FAMILY PRACTICE	0	0	0	0	0	190.04
190.05	19005	PAOLI FAMILY PRACTICE	0	0	0	7,482	0	190.05
190.06	19006	OTHER PROPERTY	0	0	0	62,545	0	190.06
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	77,798	0	487,662	32,923,315	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1306 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I | Date/Time Prepared: 5/29/2024 2:20 pm

		Cost Center Description	Total		
			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
7.01	00701	UTILITIES			7.01
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
17.00	01700	SOCIAL SERVICE			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS			19.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	5,280,548		30.00
31.00	03100	INTENSIVE CARE UNIT	0		31.00
43.00	04300	NURSERY	144,154		43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	2,505,645		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	790,260		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,555,707		54.00
60.00	06000	LABORATORY	3,564,493		60.00
64.00	06400	INTRAVENOUS THERAPY	271,096		64.00
65.00	06500	RESPIRATORY THERAPY	1,092,733		65.00
66.00	06600	PHYSICAL THERAPY	1,112,248		66.00
67.00	06700	OCCUPATIONAL THERAPY	533,650		67.00
68.00	06800	SPEECH PATHOLOGY	179,176		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	292,751		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	38,154		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,035,860		73.00
74.00	07400	RENAL DIALYSIS	0		74.00
75.00	07500	ASC (NON-DISTINCT PART)	0		75.00
76.97	07697	CARDIAC REHABILITATION	0		76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0		77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0		78.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	2,347,632		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0		89.00
90.00	09000	CLINIC	126,118		90.00
90.01	09001	VISITING SPECIALTY CLINIC	1,040,373		90.01
90.02	09002	PAOLI PRIMARY CARE CLINIC	0		90.02
91.00	09100	EMERGENCY	6,924,678		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0		95.00
101.00	10100	HOME HEALTH AGENCY	0		101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0		102.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	32,835,276		118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		190.00
190.01	19001	VISITING SPECIALTY CLINIC	0		190.01
190.02	19002	OUTREACH	18,012		190.02
190.03	19003	FOUNDATION	0		190.03
190.04	19004	SPRING VALLEY FAMILY PRACTICE	0		190.04
190.05	19005	PAOLI FAMILY PRACTICE	7,482		190.05
190.06	19006	OTHER PROPERTY	62,545		190.06
191.00	19100	RESEARCH	0		191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0		192.00
193.00	19300	NONPAID WORKERS	0		193.00
200.00		Cross Foot Adjustments	0		200.00
201.00		Negative Cost Centers	0		201.00
202.00		TOTAL (sum lines 118 through 201)	32,923,315		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1306 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II | Date/Time Prepared: 5/29/2024 2:20 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	5,484	10,505	15,989	15,989	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	212,151	29,218	55,962	297,331	529	5.00
7.00	00700	OPERATION OF PLANT	0	35,662	68,304	103,966	712	7.00
7.01	00701	UTILITIES	0	0	0	0	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	2,482	4,753	7,235	0	8.00
9.00	00900	HOUSEKEEPING	0	7,329	14,038	21,367	388	9.00
10.00	01000	DIETARY	0	14,485	27,743	42,228	161	10.00
11.00	01100	CAFETERIA	0	8,314	15,923	24,237	116	11.00
13.00	01300	NURSING ADMINISTRATION	0	15,742	30,152	45,894	1,489	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	17,306	33,146	50,452	0	14.00
15.00	01500	PHARMACY	0	9,670	18,522	28,192	570	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	6,229	11,931	18,160	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	517	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	58,903	112,827	171,730	2,756	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	0	2,068	3,961	6,029	49	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	49,857	95,493	145,350	769	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	4,856	9,301	14,157	382	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	49,518	94,844	144,362	1,509	54.00
60.00	06000	LABORATORY	0	15,494	29,676	45,170	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	3,723	7,130	10,853	130	64.00
65.00	06500	RESPIRATORY THERAPY	0	4,657	8,920	13,577	743	65.00
66.00	06600	PHYSICAL THERAPY	0	26,099	49,989	76,088	612	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	14,650	28,060	42,710	343	67.00
68.00	06800	SPEECH PATHOLOGY	0	4,889	9,364	14,253	115	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
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						
88.00	08800	RURAL HEALTH CLINIC	0	41,345	78,714	120,059	1,387	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	314	602	916	113	90.00
90.01	09001	VISITING SPECIALTY CLINIC	0	28,597	54,773	83,370	477	90.01
90.02	09002	PAOLI PRIMARY CARE CLINIC	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	0	34,206	65,516	99,722	2,122	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	212,151	491,097	940,149	1,643,397	15,989	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	VISITING SPECIALTY CLINIC	0	0	0	0	0	190.01
190.02	19002	OUTREACH	0	5,154	0	5,154	0	190.02
190.03	19003	FOUNDATION	0	0	0	0	0	190.03
190.04	19004	SPRING VALLEY FAMILY PRACTICE	0	0	0	0	0	190.04
190.05	19005	PAOLI FAMILY PRACTICE	0	0	0	0	0	190.05
190.06	19006	OTHER PROPERTY	0	23,427	0	23,427	0	190.06
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
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)	212,151	519,678	940,149	1,671,978	15,989	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1306 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II | Date/Time Prepared: 5/29/2024 2:20 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	UTILITIES	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	7.00	7.01	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	297,860					5.00
7.00	00700	OPERATION OF PLANT	17,655	122,333				7.00
7.01	00701	UTILITIES	5,486	0	5,486			7.01
8.00	00800	LAUNDRY & LINEN SERVICE	907	818	31	8,991		8.00
9.00	00900	HOUSEKEEPING	6,814	2,417	91	0	31,077	9.00
10.00	01000	DIETARY	3,630	4,777	179	0	1,158	10.00
11.00	01100	CAFETERIA	2,460	2,742	103	0	664	11.00
13.00	01300	NURSING ADMINISTRATION	16,421	3,350	195	0	1,258	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,823	5,708	214	0	0	14.00
15.00	01500	PHARMACY	7,638	3,189	120	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	214	2,054	77	0	498	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	4,333	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	30,238	19,429	725	7,771	4,708	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	774	682	26	1,220	165	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	11,671	16,444	616	0	3,985	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	5,646	1,602	60	0	388	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	18,361	16,332	612	0	3,957	54.00
60.00	06000	LABORATORY	30,665	5,110	191	0	1,238	60.00
64.00	06400	INTRAVENOUS THERAPY	1,585	1,228	46	0	298	64.00
65.00	06500	RESPIRATORY THERAPY	9,150	1,536	58	0	372	65.00
66.00	06600	PHYSICAL THERAPY	9,044	311	323	0	2,086	66.00
67.00	06700	OCCUPATIONAL THERAPY	4,291	175	181	0	1,171	67.00
68.00	06800	SPEECH PATHOLOGY	1,432	57	60	0	391	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,382	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	180	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	28,343	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
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						
88.00	08800	RURAL HEALTH CLINIC	16,455	13,554	508	0	3,284	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	1,103	104	4	0	25	90.00
90.01	09001	VISITING SPECIALTY CLINIC	5,956	9,432	353	0	2,285	90.01
90.02	09002	PAOLI PRIMARY CARE CLINIC	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	52,792	11,282	423	0	2,734	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	297,449	122,333	5,196	8,991	30,665	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	VISITING SPECIALTY CLINIC	0	0	0	0	0	190.01
190.02	19002	OUTREACH	67	0	0	0	412	190.02
190.03	19003	FOUNDATION	0	0	0	0	0	190.03
190.04	19004	SPRING VALLEY FAMILY PRACTICE	0	0	0	0	0	190.04
190.05	19005	PAOLI FAMILY PRACTICE	68	0	0	0	0	190.05
190.06	19006	OTHER PROPERTY	276	0	290	0	0	190.06
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
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)	297,860	122,333	5,486	8,991	31,077	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1306 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II | Date/Time Prepared: 5/29/2024 2:20 pm

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	UTILITIES						7.01
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	52,133					10.00
11.00	01100	CAFETERIA	0	30,322				11.00
13.00	01300	NURSING ADMINISTRATION	0	2,304	70,911			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	59,197		14.00
15.00	01500	PHARMACY	0	1,161	0	772	41,642	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	529	0	379	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	52,133	5,210	23,795	10,048	316	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	0	92	534	1,211	2	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	1,413	8,105	6,518	102	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	718	4,157	85	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,090	1,413	808	91	54.00
60.00	06000	LABORATORY	0	2,857	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	271	1,928	547	89	64.00
65.00	06500	RESPIRATORY THERAPY	0	1,472	0	3,167	0	65.00
66.00	06600	PHYSICAL THERAPY	0	1,430	0	47	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	473	0	26	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	258	0	9	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	19,399	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	2,524	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	40,087	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
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						
88.00	08800	RURAL HEALTH CLINIC	0	3,039	4,776	639	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	121	0	0	0	90.00
90.01	09001	VISITING SPECIALTY CLINIC	0	1,449	4,148	260	0	90.01
90.02	09002	PAOLI PRIMARY CARE CLINIC	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	0	4,435	22,055	12,758	955	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	52,133	30,322	70,911	59,197	41,642	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	VISITING SPECIALTY CLINIC	0	0	0	0	0	190.01
190.02	19002	OUTREACH	0	0	0	0	0	190.02
190.03	19003	FOUNDATION	0	0	0	0	0	190.03
190.04	19004	SPRING VALLEY FAMILY PRACTICE	0	0	0	0	0	190.04
190.05	19005	PAOLI FAMILY PRACTICE	0	0	0	0	0	190.05
190.06	19006	OTHER PROPERTY	0	0	0	0	0	190.06
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
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)	52,133	30,322	70,911	59,197	41,642	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1306 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II Date/Time Prepared: 5/29/2024 2:20 pm

		Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			16.00	17.00	19.00	24.00	25.00	
		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
7.01	00701	UTILITIES						7.01
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	21,003					16.00
17.00	01700	SOCIAL SERVICE	0	0				17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	5,758			19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,673	0		330,532	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0		0	0	31.00
43.00	04300	NURSERY	79	0		10,863	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,854	0		196,827	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	294	0		27,489	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,874	0		194,409	0	54.00
60.00	06000	LABORATORY	2,187	0		87,418	0	60.00
64.00	06400	INTRAVENOUS THERAPY	421	0		17,396	0	64.00
65.00	06500	RESPIRATORY THERAPY	378	0		30,453	0	65.00
66.00	06600	PHYSICAL THERAPY	428	0		90,369	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	232	0		49,602	0	67.00
68.00	06800	SPEECH PATHOLOGY	54	0		16,629	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	43	0		20,824	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	24	0		2,728	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,882	0		71,312	0	73.00
74.00	07400	RENAL DIALYSIS	0	0		0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0		0	0	75.00
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						
88.00	08800	RURAL HEALTH CLINIC	399	0		164,100	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0		0	0	89.00
90.00	09000	CLINIC	18	0		2,404	0	90.00
90.01	09001	VISITING SPECIALTY CLINIC	341	0		108,071	0	90.01
90.02	09002	PAOLI PRIMARY CARE CLINIC	0	0		0	0	90.02
91.00	09100	EMERGENCY	5,822	0		215,100	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0		0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0		0	0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0		0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	21,003	0	0	1,636,526	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0	0	190.00
190.01	19001	VISITING SPECIALTY CLINIC	0	0		0	0	190.01
190.02	19002	OUTREACH	0	0		5,633	0	190.02
190.03	19003	FOUNDATION	0	0		0	0	190.03
190.04	19004	SPRING VALLEY FAMILY PRACTICE	0	0		0	0	190.04
190.05	19005	PAOLI FAMILY PRACTICE	0	0		68	0	190.05
190.06	19006	OTHER PROPERTY	0	0		23,993	0	190.06
191.00	19100	RESEARCH	0	0		0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		0	0	192.00
193.00	19300	NONPAID WORKERS	0	0		0	0	193.00
200.00		Cross Foot Adjustments			5,758	5,758	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	21,003	0	5,758	1,671,978	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1306 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II | Date/Time Prepared: 5/29/2024 2:20 pm

		Cost Center Description	Total		
			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
7.01	00701	UTILITIES			7.01
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
17.00	01700	SOCIAL SERVICE			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS			19.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	330,532		30.00
31.00	03100	INTENSIVE CARE UNIT	0		31.00
43.00	04300	NURSERY	10,863		43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	196,827		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	27,489		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	194,409		54.00
60.00	06000	LABORATORY	87,418		60.00
64.00	06400	INTRAVENOUS THERAPY	17,396		64.00
65.00	06500	RESPIRATORY THERAPY	30,453		65.00
66.00	06600	PHYSICAL THERAPY	90,369		66.00
67.00	06700	OCCUPATIONAL THERAPY	49,602		67.00
68.00	06800	SPEECH PATHOLOGY	16,629		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	20,824		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,728		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	71,312		73.00
74.00	07400	RENAL DIALYSIS	0		74.00
75.00	07500	ASC (NON-DISTINCT PART)	0		75.00
76.97	07697	CARDIAC REHABILITATION	0		76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0		77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0		78.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	164,100		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0		89.00
90.00	09000	CLINIC	2,404		90.00
90.01	09001	VISITING SPECIALTY CLINIC	108,071		90.01
90.02	09002	PAOLI PRIMARY CARE CLINIC	0		90.02
91.00	09100	EMERGENCY	215,100		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0		95.00
101.00	10100	HOME HEALTH AGENCY	0		101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0		102.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,636,526		118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		190.00
190.01	19001	VISITING SPECIALTY CLINIC	0		190.01
190.02	19002	OUTREACH	5,633		190.02
190.03	19003	FOUNDATION	0		190.03
190.04	19004	SPRING VALLEY FAMILY PRACTICE	0		190.04
190.05	19005	PAOLI FAMILY PRACTICE	68		190.05
190.06	19006	OTHER PROPERTY	23,993		190.06
191.00	19100	RESEARCH	0		191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0		192.00
193.00	19300	NONPAID WORKERS	0		193.00
200.00		Cross Foot Adjustments	5,758		200.00
201.00		Negative Cost Centers	0		201.00
202.00		TOTAL (sum lines 118 through 201)	1,671,978		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1306 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/29/2024 2:20 pm

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS 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	62,822					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		59,337				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	663	663	10,425,487			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,532	3,532	344,902	-7,671,407	25,251,908	5.00
7.00	00700	OPERATION OF PLANT	4,311	4,311	464,037	0	1,496,656	7.00
7.01	00701	UTILITIES	0	0	0	0	465,086	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	300	300	0	0	76,920	8.00
9.00	00900	HOUSEKEEPING	886	886	252,660	0	577,646	9.00
10.00	01000	DIETARY	1,751	1,751	104,909	0	307,707	10.00
11.00	01100	CAFETERIA	1,005	1,005	75,651	0	208,555	11.00
13.00	01300	NURSING ADMINISTRATION	1,903	1,903	970,394	0	1,392,052	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,092	2,092	0	0	239,285	14.00
15.00	01500	PHARMACY	1,169	1,169	371,785	0	647,509	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	753	753	0	0	18,160	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	337,345	0	367,331	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,121	7,121	1,799,695	0	2,563,377	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	250	250	31,951	0	65,644	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,027	6,027	501,418	0	989,381	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	587	587	248,926	0	478,610	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,986	5,986	983,478	0	1,556,513	54.00
60.00	06000	LABORATORY	1,873	1,873	0	0	2,599,612	60.00
64.00	06400	INTRAVENOUS THERAPY	450	450	84,464	0	134,400	64.00
65.00	06500	RESPIRATORY THERAPY	563	563	484,132	0	775,679	65.00
66.00	06600	PHYSICAL THERAPY	3,155	3,155	398,955	0	766,741	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,771	1,771	223,903	0	363,734	67.00
68.00	06800	SPEECH PATHOLOGY	591	591	74,749	0	121,426	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	117,180	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	15,245	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	2,402,805	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
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						
88.00	08800	RURAL HEALTH CLINIC	4,998	4,968	903,920	0	1,394,962	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	38	38	73,571	0	93,535	90.00
90.01	09001	VISITING SPECIALTY CLINIC	3,457	3,457	311,045	0	504,950	90.01
90.02	09002	PAOLI PRIMARY CARE CLINIC	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	4,135	4,135	1,383,597	0	4,476,375	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	59,367	59,337	10,425,487	-7,671,407	25,217,076	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	VISITING SPECIALTY CLINIC	0	0	0	0	0	190.01
190.02	19002	OUTREACH	623	0	0	0	5,666	190.02
190.03	19003	FOUNDATION	0	0	0	0	0	190.03
190.04	19004	SPRING VALLEY FAMILY PRACTICE	0	0	0	0	0	190.04
190.05	19005	PAOLI FAMILY PRACTICE	0	0	0	0	5,739	190.05
190.06	19006	OTHER PROPERTY	2,832	0	0	0	23,427	190.06
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
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)	519,678	940,149	1,895,667		7,671,407	202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1306 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/29/2024 2:20 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	
203.00	Unit cost multiplier (Wkst. B, Part I)	8.272229	15.844229	0.181830		0.303795	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)			15,989		297,860	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)			0.001534		0.011796	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: 15-1306 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/29/2024 2:20 pm

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	UTILITIES (SQUARE FEET)	LAUNDRY & LINEN SERVICE (TOTAL PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
			7.00	7.01	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						5.00
7.00	00700	OPERATION OF PLANT	44,838					7.00
7.01	00701	UTILITIES	0	53,663				7.01
8.00	00800	LAUNDRY & LINEN SERVICE	300	300	1,828			8.00
9.00	00900	HOUSEKEEPING	886	886	0	47,007		9.00
10.00	01000	DIETARY	1,751	1,751	0	1,751	8,710	10.00
11.00	01100	CAFETERIA	1,005	1,005	0	1,005	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,228	1,903	0	1,903	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,092	2,092	0	0	0	14.00
15.00	01500	PHARMACY	1,169	1,169	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	753	753	0	753	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,121	7,121	1,580	7,121	8,710	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	250	250	248	250	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,027	6,027	0	6,027	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	587	587	0	587	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,986	5,986	0	5,986	0	54.00
60.00	06000	LABORATORY	1,873	1,873	0	1,873	0	60.00
64.00	06400	INTRAVENOUS THERAPY	450	450	0	450	0	64.00
65.00	06500	RESPIRATORY THERAPY	563	563	0	563	0	65.00
66.00	06600	PHYSICAL THERAPY	114	3,155	0	3,155	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	64	1,771	0	1,771	0	67.00
68.00	06800	SPEECH PATHOLOGY	21	591	0	591	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
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						
88.00	08800	RURAL HEALTH CLINIC	4,968	4,968	0	4,968	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	38	38	0	38	0	90.00
90.01	09001	VISITING SPECIALTY CLINIC	3,457	3,457	0	3,457	0	90.01
90.02	09002	PAOLI PRIMARY CARE CLINIC	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	4,135	4,135	0	4,135	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	44,838	50,831	1,828	46,384	8,710	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	VISITING SPECIALTY CLINIC	0	0	0	0	0	190.01
190.02	19002	OUTREACH	0	0	0	623	0	190.02
190.03	19003	FOUNDATION	0	0	0	0	0	190.03
190.04	19004	SPRING VALLEY FAMILY PRACTICE	0	0	0	0	0	190.04
190.05	19005	PAOLI FAMILY PRACTICE	0	0	0	0	0	190.05
190.06	19006	OTHER PROPERTY	0	2,832	0	0	0	190.06
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,951,333	606,377	116,734	801,702	527,039	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	43.519626	11.299722	63.858862	17.054949	60.509644	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	122,333	5,486	8,991	31,077	52,133	204.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1306 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/29/2024 2:20 pm

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	UTILITIES (SQUARE FEET)	LAUNDRY & LINEN SERVICE (TOTAL PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
			7.00	7.01	8.00	9.00	10.00	
205.00		Unit cost multiplier (Wkst. B, Part II)	2.728333	0.102231	4.918490	0.661114	5.985419	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: 15-1306 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/29/2024 2:20 pm

		Cost Center Description	CAFETERIA (MAN HOURS)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
			11.00	13.00	14.00	15.00	16.00	
		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
7.01	00701	UTILITIES						7.01
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	238,239					11.00
13.00	01300	NURSING ADMINISTRATION	18,099	78,271				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	357,586			14.00
15.00	01500	PHARMACY	9,120	0	4,664	2,495,986		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	95,600,808	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	4,160	0	2,287	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	40,947	26,266	60,699	18,957	7,603,724	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	724	589	7,313	97	356,959	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	11,102	8,946	39,373	6,106	8,426,112	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	5,641	4,588	511	0	1,335,772	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	24,278	1,560	4,880	5,471	17,607,751	54.00
60.00	06000	LABORATORY	22,444	0	0	0	9,940,372	60.00
64.00	06400	INTRAVENOUS THERAPY	2,128	2,128	3,305	5,311	1,912,448	64.00
65.00	06500	RESPIRATORY THERAPY	11,569	0	19,133	0	1,719,918	65.00
66.00	06600	PHYSICAL THERAPY	11,234	0	284	11	1,946,473	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,713	0	159	6	1,054,349	67.00
68.00	06800	SPEECH PATHOLOGY	2,026	0	53	2	244,550	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	117,179	0	195,489	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	15,245	0	107,701	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	2,402,805	13,099,055	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
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						
88.00	08800	RURAL HEALTH CLINIC	23,877	5,272	3,862	0	1,811,460	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	948	0	0	0	82,957	90.00
90.01	09001	VISITING SPECIALTY CLINIC	11,386	4,578	1,572	0	1,551,775	90.01
90.02	09002	PAOLI PRIMARY CARE CLINIC	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	34,843	24,344	77,067	57,220	26,603,943	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	238,239	78,271	357,586	2,495,986	95,600,808	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	VISITING SPECIALTY CLINIC	0	0	0	0	0	190.01
190.02	19002	OUTREACH	0	0	0	0	0	190.02
190.03	19003	FOUNDATION	0	0	0	0	0	190.03
190.04	19004	SPRING VALLEY FAMILY PRACTICE	0	0	0	0	0	190.04
190.05	19005	PAOLI FAMILY PRACTICE	0	0	0	0	0	190.05
190.06	19006	OTHER PROPERTY	0	0	0	0	0	190.06
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
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)	344,146	1,948,496	426,661	927,041	77,798	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	1.444541	24.894226	1.193170	0.371413	0.000814	203.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1306 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/29/2024 2:20 pm

		Cost Center Description	CAFETERIA (MAN HOURS)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
			11.00	13.00	14.00	15.00	16.00	
204.00		Cost to be allocated (per Wkst. B, Part II)	30,322	70,911	59,197	41,642	21,003	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.127276	0.905968	0.165546	0.016684	0.000220	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: 15-1306 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/29/2024 2:20 pm

		Cost Center Description	SOCIAL SERVICE (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)		
			17.00	19.00		
		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
7.01	00701	UTILITIES				7.01
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE	0			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	100		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	0		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0		31.00
43.00	04300	NURSERY	0	0		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	100		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	06000	LABORATORY	0	0		60.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0		75.00
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0		77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0		78.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0		89.00
90.00	09000	CLINIC	0	0		90.00
90.01	09001	VISITING SPECIALTY CLINIC	0	0		90.01
90.02	09002	PAOLI PRIMARY CARE CLINIC	0	0		90.02
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	0		95.00
101.00	10100	HOME HEALTH AGENCY	0	0		101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0		102.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	100		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
190.01	19001	VISITING SPECIALTY CLINIC	0	0		190.01
190.02	19002	OUTREACH	0	0		190.02
190.03	19003	FOUNDATION	0	0		190.03
190.04	19004	SPRING VALLEY FAMILY PRACTICE	0	0		190.04
190.05	19005	PAOLI FAMILY PRACTICE	0	0		190.05
190.06	19006	OTHER PROPERTY	0	0		190.06
191.00	19100	RESEARCH	0	0		191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		192.00
193.00	19300	NONPAID WORKERS	0	0		193.00
200.00		Cross Foot Adjustments				200.00
201.00		Negative Cost Centers				201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	0	487,662		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	4,876.620000		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0	5,758		204.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1306 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/29/2024 2:20 pm

		Cost Center Description	SOCIAL SERVICE (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)		
			17.00	19.00		
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	57.580000		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: 15-1306 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 5/29/2024 2:20 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	5,280,548		5,280,548	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0		0	0	0	31.00
43.00	04300	NURSERY	144,154		144,154	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,505,645		2,505,645	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	790,260		790,260	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,555,707		2,555,707	0	0	54.00
60.00	06000	LABORATORY	3,564,493		3,564,493	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	271,096		271,096	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,092,733	0	1,092,733	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,112,248	0	1,112,248	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	533,650	0	533,650	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	179,176	0	179,176	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	292,751		292,751	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	38,154		38,154	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,035,860		4,035,860	0	0	73.00
74.00	07400	RENAL DIALYSIS	0		0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0		0	0	0	75.00
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						
88.00	08800	RURAL HEALTH CLINIC	2,347,632		2,347,632	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	89.00
90.00	09000	CLINIC	126,118		126,118	0	0	90.00
90.01	09001	VISITING SPECIALTY CLINIC	1,040,373		1,040,373	0	0	90.01
90.02	09002	PAOLI PRIMARY CARE CLINIC	0		0	0	0	90.02
91.00	09100	EMERGENCY	6,924,678		6,924,678	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,636,703		1,636,703		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0		0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0		0		0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0		0		0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	34,471,979	0	34,471,979	0	0	200.00
201.00		Less Observation Beds	1,636,703		1,636,703		0	201.00
202.00		Total (see instructions)	32,835,276	0	32,835,276	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1306 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 5/29/2024 2:20 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,618,893		3,618,893			30.00
31.00	03100	INTENSIVE CARE UNIT	0		0			31.00
43.00	04300	NURSERY	356,959		356,959			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,006,372	7,419,740	8,426,112	0.297367	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	802,952	532,820	1,335,772	0.591613	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	654,967	16,952,784	17,607,751	0.145147	0.000000	54.00
60.00	06000	LABORATORY	1,255,215	8,685,157	9,940,372	0.358587	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	2,657	1,909,791	1,912,448	0.141753	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	433,439	1,286,479	1,719,918	0.635340	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	172,780	1,773,693	1,946,473	0.571417	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	178,244	876,105	1,054,349	0.506142	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	57,508	187,042	244,550	0.732676	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	13,660	181,829	195,489	1.497532	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	7,596	100,105	107,701	0.354259	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,541,975	11,557,080	13,099,055	0.308103	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0.000000	0.000000	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0.000000	0.000000	75.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0.000000	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						
88.00	08800	RURAL HEALTH CLINIC	0	1,811,460	1,811,460			88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0			89.00
90.00	09000	CLINIC	0	82,957	82,957	1.520282	0.000000	90.00
90.01	09001	VISITING SPECIALTY CLINIC	0	1,551,775	1,551,775	0.670441	0.000000	90.01
90.02	09002	PAOLI PRIMARY CARE CLINIC	0	0	0	0.000000	0.000000	90.02
91.00	09100	EMERGENCY	236,772	26,367,171	26,603,943	0.260288	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	8,613	3,976,218	3,984,831	0.410733	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0			102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	10,348,602	85,252,206	95,600,808			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	10,348,602	85,252,206	95,600,808			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1306 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 5/29/2024 2:20 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
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000	LABORATORY	0.000000		60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000		64.00
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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	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
74.00	07400	RENAL DIALYSIS	0.000000		74.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000		75.00
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			
88.00	08800	RURAL HEALTH CLINIC			88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER			89.00
90.00	09000	CLINIC	0.000000		90.00
90.01	09001	VISITING SPECIALTY CLINIC	0.000000		90.01
90.02	09002	PAOLI PRIMARY CARE CLINIC	0.000000		90.02
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
101.00	10100	HOME HEALTH AGENCY			101.00
102.00	10200	OPIOID TREATMENT PROGRAM			102.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1306 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 5/29/2024 2:20 pm

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	Costs RCE Disallowance	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,280,548		5,280,548	0	5,280,548	30.00
31.00	03100	INTENSIVE CARE UNIT	0		0	0	0	31.00
43.00	04300	NURSERY	144,154		144,154	0	144,154	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,505,645		2,505,645	0	2,505,645	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	790,260		790,260	0	790,260	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,555,707		2,555,707	0	2,555,707	54.00
60.00	06000	LABORATORY	3,564,493		3,564,493	0	3,564,493	60.00
64.00	06400	INTRAVENOUS THERAPY	271,096		271,096	0	271,096	64.00
65.00	06500	RESPIRATORY THERAPY	1,092,733	0	1,092,733	0	1,092,733	65.00
66.00	06600	PHYSICAL THERAPY	1,112,248	0	1,112,248	0	1,112,248	66.00
67.00	06700	OCCUPATIONAL THERAPY	533,650	0	533,650	0	533,650	67.00
68.00	06800	SPEECH PATHOLOGY	179,176	0	179,176	0	179,176	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	292,751		292,751	0	292,751	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	38,154		38,154	0	38,154	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,035,860		4,035,860	0	4,035,860	73.00
74.00	07400	RENAL DIALYSIS	0		0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0		0	0	0	75.00
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						
88.00	08800	RURAL HEALTH CLINIC	2,347,632		2,347,632	0	2,347,632	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	89.00
90.00	09000	CLINIC	126,118		126,118	0	126,118	90.00
90.01	09001	VISITING SPECIALTY CLINIC	1,040,373		1,040,373	0	1,040,373	90.01
90.02	09002	PAOLI PRIMARY CARE CLINIC	0		0	0	0	90.02
91.00	09100	EMERGENCY	6,924,678		6,924,678	0	6,924,678	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,636,703		1,636,703		1,636,703	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0		0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0		0		0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0		0		0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	34,471,979	0	34,471,979	0	34,471,979	200.00
201.00		Less Observation Beds	1,636,703		1,636,703		1,636,703	201.00
202.00		Total (see instructions)	32,835,276	0	32,835,276	0	32,835,276	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1306 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 5/29/2024 2:20 pm

Title XIX | Hospital | PPS

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,618,893		3,618,893			30.00
31.00	03100	INTENSIVE CARE UNIT	0		0			31.00
43.00	04300	NURSERY	356,959		356,959			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,006,372	7,419,740	8,426,112	0.297367	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	802,952	532,820	1,335,772	0.591613	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	654,967	16,952,784	17,607,751	0.145147	0.000000	54.00
60.00	06000	LABORATORY	1,255,215	8,685,157	9,940,372	0.358587	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	2,657	1,909,791	1,912,448	0.141753	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	433,439	1,286,479	1,719,918	0.635340	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	172,780	1,773,693	1,946,473	0.571417	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	178,244	876,105	1,054,349	0.506142	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	57,508	187,042	244,550	0.732676	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	13,660	181,829	195,489	1.497532	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	7,596	100,105	107,701	0.354259	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,541,975	11,557,080	13,099,055	0.308103	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0.000000	0.000000	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0.000000	0.000000	75.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0.000000	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						
88.00	08800	RURAL HEALTH CLINIC	0	1,811,460	1,811,460	1.295989	0.000000	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.000000	0.000000	89.00
90.00	09000	CLINIC	0	82,957	82,957	1.520282	0.000000	90.00
90.01	09001	VISITING SPECIALTY CLINIC	0	1,551,775	1,551,775	0.670441	0.000000	90.01
90.02	09002	PAOLI PRIMARY CARE CLINIC	0	0	0	0.000000	0.000000	90.02
91.00	09100	EMERGENCY	236,772	26,367,171	26,603,943	0.260288	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	8,613	3,976,218	3,984,831	0.410733	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0			102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	10,348,602	85,252,206	95,600,808			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	10,348,602	85,252,206	95,600,808			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1306 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 5/29/2024 2:20 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
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.297367		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.591613		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.145147		54.00
60.00	06000	LABORATORY	0.358587		60.00
64.00	06400	INTRAVENOUS THERAPY	0.141753		64.00
65.00	06500	RESPIRATORY THERAPY	0.635340		65.00
66.00	06600	PHYSICAL THERAPY	0.571417		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.506142		67.00
68.00	06800	SPEECH PATHOLOGY	0.732676		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.497532		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.354259		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.308103		73.00
74.00	07400	RENAL DIALYSIS	0.000000		74.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000		75.00
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			
88.00	08800	RURAL HEALTH CLINIC	1.295989		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		89.00
90.00	09000	CLINIC	1.520282		90.00
90.01	09001	VISITING SPECIALTY CLINIC	0.670441		90.01
90.02	09002	PAOLI PRIMARY CARE CLINIC	0.000000		90.02
91.00	09100	EMERGENCY	0.260288		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.410733		92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
101.00	10100	HOME HEALTH AGENCY			101.00
102.00	10200	OPIOID TREATMENT PROGRAM			102.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

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

Provider CCN: 15-1306 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part II | Date/Time Prepared: 5/29/2024 2:20 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	2,505,645	196,827	2,308,818	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	790,260	27,489	762,771	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,555,707	194,409	2,361,298	0	0	54.00
60.00	06000	LABORATORY	3,564,493	87,418	3,477,075	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	271,096	17,396	253,700	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,092,733	30,453	1,062,280	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,112,248	90,369	1,021,879	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	533,650	49,602	484,048	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	179,176	16,629	162,547	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	292,751	20,824	271,927	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	38,154	2,728	35,426	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,035,860	71,312	3,964,548	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
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						
88.00	08800	RURAL HEALTH CLINIC	2,347,632	164,100	2,183,532	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	126,118	2,404	123,714	0	0	90.00
90.01	09001	VISITING SPECIALTY CLINIC	1,040,373	108,071	932,302	0	0	90.01
90.02	09002	PAOLI PRIMARY CARE CLINIC	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	6,924,678	215,100	6,709,578	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,636,703	102,448	1,534,255	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (sum of lines 50 thru 199)	29,047,277	1,397,579	27,649,698	0	0	200.00
201.00		Less Observation Beds	1,636,703	102,448	1,534,255	0	0	201.00
202.00		Total (line 200 minus line 201)	27,410,574	1,295,131	26,115,443	0	0	202.00

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

Provider CCN: 15-1306 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part II | Date/Time Prepared: 5/29/2024 2:20 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	2,505,645	8,426,112	0.297367		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	790,260	1,335,772	0.591613		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,555,707	17,607,751	0.145147		54.00
60.00	06000	LABORATORY	3,564,493	9,940,372	0.358587		60.00
64.00	06400	INTRAVENOUS THERAPY	271,096	1,912,448	0.141753		64.00
65.00	06500	RESPIRATORY THERAPY	1,092,733	1,719,918	0.635340		65.00
66.00	06600	PHYSICAL THERAPY	1,112,248	1,946,473	0.571417		66.00
67.00	06700	OCCUPATIONAL THERAPY	533,650	1,054,349	0.506142		67.00
68.00	06800	SPEECH PATHOLOGY	179,176	244,550	0.732676		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	292,751	195,489	1.497532		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	38,154	107,701	0.354259		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,035,860	13,099,055	0.308103		73.00
74.00	07400	RENAL DIALYSIS	0	0	0.000000		74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0.000000		75.00
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000		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					
88.00	08800	RURAL HEALTH CLINIC	2,347,632	1,811,460	1.295989		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000		89.00
90.00	09000	CLINIC	126,118	82,957	1.520282		90.00
90.01	09001	VISITING SPECIALTY CLINIC	1,040,373	1,551,775	0.670441		90.01
90.02	09002	PAOLI PRIMARY CARE CLINIC	0	0	0.000000		90.02
91.00	09100	EMERGENCY	6,924,678	26,603,943	0.260288		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,636,703	3,984,831	0.410733		92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0	0	0.000000		95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0.000000		101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0.000000		102.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (sum of lines 50 thru 199)	29,047,277	91,624,956			200.00
201.00		Less Observation Beds	1,636,703	0			201.00
202.00		Total (line 200 minus line 201)	27,410,574	91,624,956			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-1306 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part II Date/Time Prepared: 5/29/2024 2:20 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	196,827	8,426,112	0.023359	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	27,489	1,335,772	0.020579	7,409	152	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	194,409	17,607,751	0.011041	240,270	2,653	54.00
60.00	06000	LABORATORY	87,418	9,940,372	0.008794	370,931	3,262	60.00
64.00	06400	INTRAVENOUS THERAPY	17,396	1,912,448	0.009096	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	30,453	1,719,918	0.017706	164,495	2,913	65.00
66.00	06600	PHYSICAL THERAPY	90,369	1,946,473	0.046427	87,804	4,076	66.00
67.00	06700	OCCUPATIONAL THERAPY	49,602	1,054,349	0.047045	91,103	4,286	67.00
68.00	06800	SPEECH PATHOLOGY	16,629	244,550	0.067998	37,900	2,577	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	20,824	195,489	0.106523	860	92	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,728	107,701	0.025329	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	71,312	13,099,055	0.005444	568,280	3,094	73.00
74.00	07400	RENAL DIALYSIS	0	0	0.000000	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0.000000	0	0	75.00
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000	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						
88.00	08800	RURAL HEALTH CLINIC	164,100	1,811,460	0.090590	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
90.00	09000	CLINIC	2,404	82,957	0.028979	0	0	90.00
90.01	09001	VISITING SPECIALTY CLINIC	108,071	1,551,775	0.069643	0	0	90.01
90.02	09002	PAOLI PRIMARY CARE CLINIC	0	0	0.000000	0	0	90.02
91.00	09100	EMERGENCY	215,100	26,603,943	0.008085	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	102,448	3,984,831	0.025709	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	1,397,579	91,624,956		1,569,052	23,105	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1306 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV | Date/Time Prepared: 5/29/2024 2:20 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	487,662	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
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						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	VISITING SPECIALTY CLINIC	0	0	0	0	0	90.01
90.02	09002	PAOLI PRIMARY CARE CLINIC	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	487,662	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1306 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV | Date/Time Prepared: 5/29/2024 2:20 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	487,662	0	8,426,112	0.057875	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	1,335,772	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	17,607,751	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	9,940,372	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	1,912,448	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	1,719,918	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	1,946,473	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,054,349	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	244,550	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	195,489	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	107,701	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	13,099,055	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0.000000	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0.000000	75.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	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						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	1,811,460	0.000000	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0.000000	89.00
90.00	09000	CLINIC	0	0	0	82,957	0.000000	90.00
90.01	09001	VISITING SPECIALTY CLINIC	0	0	0	1,551,775	0.000000	90.01
90.02	09002	PAOLI PRIMARY CARE CLINIC	0	0	0	0	0.000000	90.02
91.00	09100	EMERGENCY	0	0	0	26,603,943	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	3,984,831	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	487,662	0	91,624,956		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1306 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV | Date/Time Prepared: 5/29/2024 2:20 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	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	7,409	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	240,270	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	370,931	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	164,495	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	87,804	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	91,103	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	37,900	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	860	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	568,280	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	0	0	75.00
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						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0	0	0	89.00
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	VISITING SPECIALTY CLINIC	0.000000	0	0	0	0	90.01
90.02	09002	PAOLI PRIMARY CARE CLINIC	0.000000	0	0	0	0	90.02
91.00	09100	EMERGENCY	0.000000	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		1,569,052	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1306 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part V Date/Time Prepared: 5/29/2024 2:20 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	0.297367	0	745,831	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.591613	0	3,092	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.145147	0	3,239,611	0	0	54.00
60.00	06000	LABORATORY	0.358587	0	1,378,781	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.141753	0	642,563	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.635340	0	253,286	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.571417	0	382,726	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.506142	0	114,994	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.732676	0	20,691	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.497532	0	30,663	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.354259	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.308103	0	4,625,190	2,750	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	0	0	75.00
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						
88.00	08800	RURAL HEALTH CLINIC						88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER						89.00
90.00	09000	CLINIC	1.520282	0	33,810	0	0	90.00
90.01	09001	VISITING SPECIALTY CLINIC	0.670441	0	433,005	0	0	90.01
90.02	09002	PAOLI PRIMARY CARE CLINIC	0.000000	0	0	0	0	90.02
91.00	09100	EMERGENCY	0.260288	0	4,627,019	1,666	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.410733	0	758,188	909	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.000000		0			95.00
200.00		Subtotal (see instructions)		0	17,289,450	5,325	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	17,289,450	5,325	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1306 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part V | Date/Time Prepared: 5/29/2024 2:20 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	221,786	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,829	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	470,220	0		54.00
60.00	06000	LABORATORY	494,413	0		60.00
64.00	06400	INTRAVENOUS THERAPY	91,085	0		64.00
65.00	06500	RESPIRATORY THERAPY	160,923	0		65.00
66.00	06600	PHYSICAL THERAPY	218,696	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	58,203	0		67.00
68.00	06800	SPEECH PATHOLOGY	15,160	0		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	45,919	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,425,035	847		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0		75.00
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0		77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0		78.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC				88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER				89.00
90.00	09000	CLINIC	51,401	0		90.00
90.01	09001	VISITING SPECIALTY CLINIC	290,304	0		90.01
90.02	09002	PAOLI PRIMARY CARE CLINIC	0	0		90.02
91.00	09100	EMERGENCY	1,204,358	434		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	311,413	373		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	5,060,745	1,654		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	5,060,745	1,654		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 15-1306 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part I | Date/Time Prepared: 5/29/2024 2:20 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	330,532	2,954	327,578	2,299	142.49	30.00
31.00	INTENSIVE CARE UNIT	0		0	0	0.00	31.00
43.00	NURSERY	10,863		10,863	248	43.80	43.00
200.00	Total (lines 30 through 199)	341,395		338,441	2,547		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	42	5,985				30.00
31.00	INTENSIVE CARE UNIT	0	0				31.00
43.00	NURSERY	24	1,051				43.00
200.00	Total (lines 30 through 199)	66	7,036				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-1306 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part II Date/Time Prepared: 5/29/2024 2:20 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	196,827	8,426,112	0.023359	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	27,489	1,335,772	0.020579	11,811	243	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	194,409	17,607,751	0.011041	51,165	565	54.00
60.00	06000	LABORATORY	87,418	9,940,372	0.008794	59,627	524	60.00
64.00	06400	INTRAVENOUS THERAPY	17,396	1,912,448	0.009096	2,657	24	64.00
65.00	06500	RESPIRATORY THERAPY	30,453	1,719,918	0.017706	9,242	164	65.00
66.00	06600	PHYSICAL THERAPY	90,369	1,946,473	0.046427	2,948	137	66.00
67.00	06700	OCCUPATIONAL THERAPY	49,602	1,054,349	0.047045	3,188	150	67.00
68.00	06800	SPEECH PATHOLOGY	16,629	244,550	0.067998	636	43	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	20,824	195,489	0.106523	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,728	107,701	0.025329	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	71,312	13,099,055	0.005444	57,971	316	73.00
74.00	07400	RENAL DIALYSIS	0	0	0.000000	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0.000000	0	0	75.00
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000	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						
88.00	08800	RURAL HEALTH CLINIC	164,100	1,811,460	0.090590	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
90.00	09000	CLINIC	2,404	82,957	0.028979	0	0	90.00
90.01	09001	VISITING SPECIALTY CLINIC	108,071	1,551,775	0.069643	0	0	90.01
90.02	09002	PAOLI PRIMARY CARE CLINIC	0	0	0.000000	0	0	90.02
91.00	09100	EMERGENCY	215,100	26,603,943	0.008085	36,908	298	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	102,448	3,984,831	0.025709	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	1,397,579	91,624,956		236,153	2,464	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1306 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part III Date/Time Prepared: 5/29/2024 2:20 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
43.00	04300	NURSERY	0	0	0	0	0	43.00
200.00		Total (lines 30 through 199)	0	0	0	0	0	200.00

		Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
			4.00	5.00	6.00	7.00	8.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	2,299	0.00	42	30.00
31.00	03100	INTENSIVE CARE UNIT		0	0	0.00	0	31.00
43.00	04300	NURSERY		0	248	0.00	24	43.00
200.00		Total (lines 30 through 199)		0	2,547		66	200.00

		Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
			9.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	31.00
43.00	04300	NURSERY	0	43.00
200.00		Total (lines 30 through 199)	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1306 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV Date/Time Prepared: 5/29/2024 2:20 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	487,662	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
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						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	VISITING SPECIALTY CLINIC	0	0	0	0	0	90.01
90.02	09002	PAOLI PRIMARY CARE CLINIC	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	487,662	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1306 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV | Date/Time Prepared: 5/29/2024 2:20 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	487,662	0	8,426,112	0.057875	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	1,335,772	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	17,607,751	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	9,940,372	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	1,912,448	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	1,719,918	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	1,946,473	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,054,349	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	244,550	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	195,489	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	107,701	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	13,099,055	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0.000000	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0.000000	75.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	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						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	1,811,460	0.000000	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0.000000	89.00
90.00	09000	CLINIC	0	0	0	82,957	0.000000	90.00
90.01	09001	VISITING SPECIALTY CLINIC	0	0	0	1,551,775	0.000000	90.01
90.02	09002	PAOLI PRIMARY CARE CLINIC	0	0	0	0	0.000000	90.02
91.00	09100	EMERGENCY	0	0	0	26,603,943	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	3,984,831	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	487,662	0	91,624,956		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1306 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV | Date/Time Prepared: 5/29/2024 2:20 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	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	11,811	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	51,165	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	59,627	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	2,657	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	9,242	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	2,948	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	3,188	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	636	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	57,971	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	0	0	75.00
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						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0	0	0	89.00
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	VISITING SPECIALTY CLINIC	0.000000	0	0	0	0	90.01
90.02	09002	PAOLI PRIMARY CARE CLINIC	0.000000	0	0	0	0	90.02
91.00	09100	EMERGENCY	0.000000	36,908	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		236,153	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1306 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part V Date/Time Prepared: 5/29/2024 2:20 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	0.297367	0	45,289	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.591613	0	11,516	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.145147	0	279,341	0	0	54.00
60.00	06000	LABORATORY	0.358587	0	176,856	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.141753	0	28,999	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.635340	0	28,546	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.571417	0	19,508	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.506142	0	13,187	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.732676	0	18,742	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.497532	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.354259	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.308103	0	207,605	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	0	0	75.00
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						
88.00	08800	RURAL HEALTH CLINIC						88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER						89.00
90.00	09000	CLINIC	1.520282	0	160	0	0	90.00
90.01	09001	VISITING SPECIALTY CLINIC	0.670441	0	44,329	0	0	90.01
90.02	09002	PAOLI PRIMARY CARE CLINIC	0.000000	0	0	0	0	90.02
91.00	09100	EMERGENCY	0.260288	0	605,388	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.410733	0	140,442	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.000000	0	0			95.00
200.00		Subtotal (see instructions)		0	1,619,908	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	1,619,908	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1306 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part V Date/Time Prepared: 5/29/2024 2:20 pm

Title XIX | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	13,467	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	6,813	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	40,546	0		54.00
60.00	06000	LABORATORY	63,418	0		60.00
64.00	06400	INTRAVENOUS THERAPY	4,111	0		64.00
65.00	06500	RESPIRATORY THERAPY	18,136	0		65.00
66.00	06600	PHYSICAL THERAPY	11,147	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	6,674	0		67.00
68.00	06800	SPEECH PATHOLOGY	13,732	0		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	63,964	0		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0		75.00
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0		77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0		78.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC				88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER				89.00
90.00	09000	CLINIC	243	0		90.00
90.01	09001	VISITING SPECIALTY CLINIC	29,720	0		90.01
90.02	09002	PAOLI PRIMARY CARE CLINIC	0	0		90.02
91.00	09100	EMERGENCY	157,575	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	57,684	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	487,230	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	487,230	0		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1306 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/29/2024 2:20 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)	2,363	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,299	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)	1,580	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	15	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	49	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)	653	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)	15	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)	5,280,548	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)	13,050	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)	47,195	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	5,233,353	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)	5,233,353	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)	2,276.36	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,486,463	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)	1,486,463	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1306 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/29/2024 2:20 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)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	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)	577,207	48.00
48.01	Program inpatient cellular therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1)	0	48.01
49.00	Total Program inpatient costs (sum of lines 41 through 48.01)(see instructions)	2,063,670	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)	34,145	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	34,145	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)	719	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	2,276.36	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,636,703	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1306 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/29/2024 2:20 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	330,532	5,280,548	0.062594	1,636,703	102,448	90.00
91.00	Nursing Program cost	0	5,280,548	0.000000	1,636,703	0	91.00
92.00	Allied health cost	0	5,280,548	0.000000	1,636,703	0	92.00
93.00	All other Medical Education	0	5,280,548	0.000000	1,636,703	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1306 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/29/2024 2:20 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)	2,363	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,299	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)	1,580	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	15	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	49	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)	42	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)	248	15.00
16.00	Nursery days (title V or XIX only)	24	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)	5,280,548	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)	13,050	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)	47,195	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	5,233,353	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)	5,233,353	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)	2,276.36	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	95,607	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)	95,607	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1306 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/29/2024 2:20 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)	144,154	248	581.27	24	13,950	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	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)	73,277	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)	182,834	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)	7,036	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	2,464	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	9,500	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	173,334	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)	719	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	2,276.36	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,636,703	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1306 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/29/2024 2:20 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	330,532	5,280,548	0.062594	1,636,703	102,448	90.00
91.00	Nursing Program cost	0	5,280,548	0.000000	1,636,703	0	91.00
92.00	Allied health cost	0	5,280,548	0.000000	1,636,703	0	92.00
93.00	All other Medical Education	0	5,280,548	0.000000	1,636,703	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1306 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-3 | Date/Time Prepared: 5/29/2024 2:20 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		1,419,680		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.297367	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.591613	7,409	4,383	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.145147	240,270	34,874	54.00
60.00	06000	LABORATORY	0.358587	370,931	133,011	60.00
64.00	06400	INTRAVENOUS THERAPY	0.141753	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.635340	164,495	104,510	65.00
66.00	06600	PHYSICAL THERAPY	0.571417	87,804	50,173	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.506142	91,103	46,111	67.00
68.00	06800	SPEECH PATHOLOGY	0.732676	37,900	27,768	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.497532	860	1,288	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.354259	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.308103	568,280	175,089	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	75.00
76.97	07697	CARDIAC REHABILITATION	0.000000	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				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
90.00	09000	CLINIC	1.520282	0	0	90.00
90.01	09001	VISITING SPECIALTY CLINIC	0.670441	0	0	90.01
90.02	09002	PAOLI PRIMARY CARE CLINIC	0.000000	0	0	90.02
91.00	09100	EMERGENCY	0.260288	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.410733	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		1,569,052	577,207	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)		1,569,052		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-1306 | Component CCN: 15-Z306 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-3 | Date/Time Prepared: 5/29/2024 2:20 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
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.297367	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.591613	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.145147	0	0	54.00
60.00	06000	LABORATORY	0.358587	315	113	60.00
64.00	06400	INTRAVENOUS THERAPY	0.141753	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.635340	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.571417	3,461	1,978	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.506142	5,480	2,774	67.00
68.00	06800	SPEECH PATHOLOGY	0.732676	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.497532	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.354259	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.308103	1,113	343	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	75.00
76.97	07697	CARDIAC REHABILITATION	0.000000	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				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
90.00	09000	CLINIC	1.520282	0	0	90.00
90.01	09001	VISITING SPECIALTY CLINIC	0.670441	0	0	90.01
90.02	09002	PAOLI PRIMARY CARE CLINIC	0.000000	0	0	90.02
91.00	09100	EMERGENCY	0.260288	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.410733	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		10,369	5,208	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)		10,369		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1306 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-3 | Date/Time Prepared: 5/29/2024 2:20 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		92,646		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
43.00	04300	NURSERY		36,203		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.297367	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.591613	11,811	6,988	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.145147	51,165	7,426	54.00
60.00	06000	LABORATORY	0.358587	59,627	21,381	60.00
64.00	06400	INTRAVENOUS THERAPY	0.141753	2,657	377	64.00
65.00	06500	RESPIRATORY THERAPY	0.635340	9,242	5,872	65.00
66.00	06600	PHYSICAL THERAPY	0.571417	2,948	1,685	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.506142	3,188	1,614	67.00
68.00	06800	SPEECH PATHOLOGY	0.732676	636	466	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.497532	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.354259	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.308103	57,971	17,861	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	75.00
76.97	07697	CARDIAC REHABILITATION	0.000000	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				
88.00	08800	RURAL HEALTH CLINIC	1.295989	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0	89.00
90.00	09000	CLINIC	1.520282	0	0	90.00
90.01	09001	VISITING SPECIALTY CLINIC	0.670441	0	0	90.01
90.02	09002	PAOLI PRIMARY CARE CLINIC	0.000000	0	0	90.02
91.00	09100	EMERGENCY	0.260288	36,908	9,607	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.410733	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		236,153	73,277	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)		236,153		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-1306 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E Part B Date/Time Prepared: 5/29/2024 2:20 pm

Title XVIII | Hospital | Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	5,062,399	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)	5,062,399	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)	5,113,023	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)	64,844	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	3,039,188	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)	2,008,991	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)	2,008,991	30.00
31.00	Primary payer payments	310	31.00
32.00	Subtotal (line 30 minus line 31)	2,008,681	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)	503,026	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	326,967	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	433,606	36.00
37.00	Subtotal (see instructions)	2,335,648	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)	2,335,648	40.00
40.01	Sequestration adjustment (see instructions)	46,713	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	2,041,958	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)	246,977	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	260,172	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: 15-1306	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part B Date/Time Prepared: 5/29/2024 2:20 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: 15-1306 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E-1 Part I | Date/Time Prepared: 5/29/2024 2:20 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		2,113,171		2,041,958	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)		2,113,171		2,041,958	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		246,977	6.01
6.02	SETTLEMENT TO PROGRAM		253,954		0	6.02
7.00	Total Medicare program liability (see instructions)		1,859,217		2,288,935	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: 15-1306 | Component CCN: 15-Z306 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E-1 Part I | Date/Time Prepared: 5/29/2024 2:20 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		45,144		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)		45,144		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		6,193		0	6.02
7.00	Total Medicare program liability (see instructions)		38,951		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: 15-1306	Period: From 01/01/2023 To 12/31/2023	Worksheet E-1 Part II Date/Time Prepared: 5/29/2024 2:20 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: 15-1306 Component CCN: 15-Z306	Period: From 01/01/2023 To 12/31/2023	Worksheet E-2 Date/Time Prepared: 5/29/2024 2:20 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)	34,486	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)	5,260	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	15	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)	39,746	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	39,746	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)	39,746	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)	39,746	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)	39,746	0	19.00
19.01	Sequestration adjustment (see instructions)	795	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	45,144	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)	-6,193	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	1,688	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: 15-1306	Period: From 01/01/2023 To 12/31/2023	Worksheet E-3 Part V Date/Time Prepared: 5/29/2024 2:20 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	2,063,670	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)	2,063,670	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	2,084,307	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)	2,084,307	19.00
20.00	Deductibles (exclude professional component)	199,868	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	1,884,439	22.00
23.00	Coinsurance	5,200	23.00
24.00	Subtotal (line 22 minus line 23)	1,879,239	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	27,570	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	17,921	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	25,192	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	1,897,160	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)	1,897,160	30.00
30.01	Sequestration adjustment (see instructions)	37,943	30.01
30.02	Demonstration payment adjustment amount after sequestration	0	30.02
30.03	Sequestration adjustment-PARHM		30.03
31.00	Interim payments	2,113,171	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)	-253,954	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	88,480	34.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 15-1306 | Period: From 01/01/2023 To 12/31/2023 | Worksheet G | Date/Time Prepared: 5/29/2024 2:20 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	23,589,339	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	3,412,927	0	0	0	4.00
5.00	Other receivable	288,495	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	676,860	0	0	0	7.00
8.00	Prepaid expenses	109,125	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)	28,076,746	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	183,505	0	0	0	12.00
13.00	Land improvements	625,604	0	0	0	13.00
14.00	Accumulated depreciation	-460,508	0	0	0	14.00
15.00	Buildings	11,267,245	0	0	0	15.00
16.00	Accumulated depreciation	-4,732,396	0	0	0	16.00
17.00	Leasehold improvements	791,602	0	0	0	17.00
18.00	Accumulated depreciation	-791,602	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	80,607	0	0	0	21.00
22.00	Accumulated depreciation	-65,025	0	0	0	22.00
23.00	Major movable equipment	13,222,081	0	0	0	23.00
24.00	Accumulated depreciation	-9,624,793	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)	10,496,320	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	1,386,360	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	10,191,394	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	11,577,754	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	50,150,820	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	2,849,976	0	0	0	37.00
38.00	Salaries, wages, and fees payable	653,588	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	4,673,217	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	8,176,781	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	59,365	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	59,365	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	8,236,146	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	41,914,674				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)	41,914,674	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	50,150,820	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-1306 | Period: From 01/01/2023 To 12/31/2023 | Worksheet G-1 | Date/Time Prepared: 5/29/2024 2:20 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		40,059,793		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		1,854,881				2.00
3.00	Total (sum of line 1 and line 2)		41,914,674		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		41,914,674		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)		41,914,674		0		19.00

		Endowment Fund	Plant Fund		
		6.00	7.00	8.00	
1.00	Fund balances at beginning of period	0		0	1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)				2.00
3.00	Total (sum of line 1 and line 2)	0		0	3.00
4.00	Additions (credit adjustments) (specify)		0		4.00
5.00			0		5.00
6.00			0		6.00
7.00			0		7.00
8.00			0		8.00
9.00			0		9.00
10.00	Total additions (sum of line 4-9)	0		0	10.00
11.00	Subtotal (line 3 plus line 10)	0		0	11.00
12.00	Deductions (debit adjustments) (specify)		0		12.00
13.00			0		13.00
14.00			0		14.00
15.00			0		15.00
16.00			0		16.00
17.00			0		17.00
18.00	Total deductions (sum of lines 12-17)	0		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0	19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 15-1306 | Period: From 01/01/2023 To 12/31/2023 | Worksheet G-2 Parts I & II Date/Time Prepared: 5/29/2024 2:20 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	3,914,220		3,914,220	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	61,632		61,632	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)	3,975,852		3,975,852	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	0		0	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	3,975,852		3,975,852	17.00
18.00	Ancillary services	6,127,365	51,462,624	57,589,989	18.00
19.00	Outpatient services	245,385	31,978,121	32,223,506	19.00
20.00	RURAL HEALTH CLINIC	0	1,811,460	1,811,460	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		0	0	22.00
23.00	AMBULANCE SERVICES	0	0	0	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER NRCC	0	14,550	14,550	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	10,348,602	85,266,755	95,615,357	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		33,756,548		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)		33,756,548		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 15-1306	Period: From 01/01/2023 To 12/31/2023	Worksheet G-3 Date/Time Prepared: 5/29/2024 2:20 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	95,615,357	1.00
2.00	Less contractual allowances and discounts on patients' accounts	62,729,466	2.00
3.00	Net patient revenues (line 1 minus line 2)	32,885,891	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	33,756,548	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-870,657	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	2,725,538	24.00
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (sum of lines 6-24)	2,725,538	25.00
26.00	Total (line 5 plus line 25)	1,854,881	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)	1,854,881	29.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1306 | Component CCN: 15-8557 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-1 | Date/Time Prepared: 5/29/2024 2:20 pm

RHC I | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	0	0	0	0	0	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	448,212	92,632	540,844	-51,781	489,063	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	0	0	0	0	0	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
7.10	Marriage and Family Therapist						7.10
7.11	Mental Health Counselor						7.11
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	455,708	4,052	459,760	0	459,760	9.00
10.00	Subtotal (sum of lines 1 through 9)	903,920	96,684	1,000,604	-51,781	948,823	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	71,712	71,712	-2,198	69,514	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	71,712	71,712	-2,198	69,514	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	903,920	168,396	1,072,316	-53,979	1,018,337	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	226,115	226,115	-215,317	10,798	29.00
30.00	Administrative Costs	0	167,943	167,943	-123,390	44,553	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	394,058	394,058	-338,707	55,351	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	903,920	562,454	1,466,374	-392,686	1,073,688	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1306 | Component CCN: 15-8557 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-1 | Date/Time Prepared: 5/29/2024 2:20 pm

RHC I | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	0		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	489,063		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	0		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
7.10	Marriage and Family Therapist				7.10
7.11	Mental Health Counselor				7.11
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	459,760		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	948,823		10.00
11.00	Physician Services Under Agreement	0	0		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0		14.00
15.00	Medical Supplies	0	69,514		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	69,514		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	1,018,337		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	0	0		25.01
25.02	Chronic Care Management	0	0		25.02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	36,922	47,720		29.00
30.00	Administrative Costs	-67	44,486		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	36,855	92,206		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	36,855	1,110,543		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 15-1306 | Component CCN: 15-8557 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-2 | Date/Time Prepared: 5/29/2024 2:20 pm

RHC I | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.00	0	4,200	0		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	2.68	10,760	2,100	5,628		3.00
4.00	Subtotal (sum of lines 1 through 3)	2.68	10,760		5,628	10,760	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
7.03	Marriage and Family Therapist						7.03
7.04	Mental Health Counselor						7.04
8.00	Total FTEs and Visits (sum of lines 4 through 7)	2.68	10,760			10,760	8.00
9.00	Physician Services Under Agreements		0			0	9.00

		1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES		
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)	1,018,337	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)	0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)	1,018,337	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)	1.000000	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)	92,206	14.00
15.00	Parent provider overhead allocated to facility (see instructions)	1,237,089	15.00
16.00	Total overhead (sum of lines 14 and 15)	1,329,295	16.00
17.00	Allowable GME overhead (see instructions)	0	17.00
18.00	Enter the amount from line 16	1,329,295	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)	1,329,295	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)	2,347,632	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 15-1306 Component CCN: 15-8557	Period: From 01/01/2023 To 12/31/2023	Worksheet M-3 Date/Time Prepared: 5/29/2024 2:20 pm
	Title XVIII	RHC I	Cost

			1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES			
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)		2,347,632	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)		185	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)		2,347,447	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		10,760	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)		0	5.00
6.00	Total adjusted visits (line 4 plus line 5)		10,760	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		218.16	7.00

		Calculation of Limit (1)		
		Rate Period N/A	Rate Period 1 (01/01/2023 through 12/31/2023)	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	0.00	231.05	8.00
9.00	Rate for Program covered visits (see instructions)	0.00	218.16	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	600	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	130,896	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)			15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	130,896	16.00
16.01	Total program charges (see instructions)(from contractor's records)		96,768	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		3,173	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		4,292	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		92,831	16.04
16.05	Total program cost (see instructions)	0	97,123	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		10,565	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		16,606	19.00
20.00	Net program cost excluding injections/infusions (see instructions)		97,123	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		37	21.00
21.50	Total program IOP OPPS payments (see instructions)			21.50
21.55	Total program IOP Costs (see instructions)			21.55
21.60	Program IOP deductible and coinsurance (see instructions)			21.60
22.00	Total reimbursable Program cost (sum of lines 20, 21, 21.50, minus line 21.60)		97,160	22.00
23.00	Allowable bad debts (see instructions)		727	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		473	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		677	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	25.50
25.99	Demonstration payment adjustment amount before sequestration		0	25.99
26.00	Net reimbursable amount (see instructions)		97,633	26.00
26.01	Sequestration adjustment (see instructions)		1,953	26.01
26.02	Demonstration payment adjustment amount after sequestration		34,416	26.02
27.00	Interim payments		66,845	27.00
28.00	Tentative settlement (for contractor use only)		0	28.00
29.00	Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)		-5,581	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		4,480	30.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 15-1306 | Component CCN: 15-8557 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-4 | Date/Time Prepared: 5/29/2024 2:20 pm

Title XVIII | RHC I | Cost

		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	948,823	948,823	948,823	948,823	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000000	0.000000	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	0	0	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	0	80	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	0	80	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	1,018,337	1,018,337	1,018,337	1,018,337	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	1,329,295	1,329,295	1,329,295	1,329,295	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.000000	0.000079	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	0	105	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	0	185	0	0	10.00
11.00	Total number of injections/infusions (from your records)	0	5	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	0.00	37.00	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	0	1	0	0	13.00
13.01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13.01
14.00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	0	37	0	0	14.00

			COST OF INJECTIONS / INFUSIONS AND ADMINISTRATION	
		1.00	2.00	
15.00	Total cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst. M-3, line 2)		185	15.00
16.00	Total Program cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 14) (transfer this amount to Wkst. M-3, line 21)		37	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 15-1306 Component CCN: 15-8557	Period: From 01/01/2023 To 12/31/2023	Worksheet M-5 Date/Time Prepared: 5/29/2024 2:20 pm
		RHC I	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		66,845	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	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			0	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
	Provider to Program			
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		66,845	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			0	5.01
5.02			0	5.02
5.03			0	5.03
	Provider to Program			
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		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	6.01
6.02	SETTLEMENT TO PROGRAM		5,581	6.02
7.00	Total Medicare program liability (see instructions)		61,264	7.00

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