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: 15-1311	Period: From 01/01/2023 To 12/31/2023	Worksheet S Parts I-III Date/Time Prepared: 5/29/2024 2:28 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report   Date: 5/29/2024   Time: 2:28 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 TIPTON HOSPITAL (15-1311) 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	Cara Breidster		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	Cara Breidster			2
3	Signatory Title	CFO			3
4	Date	(Dated when report is electronica			4

		Title V	Title XVIII		HIT	Title XIX	
			Part A	Part B			
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	HOSPITAL	0	8,121	85,720	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	64,126	0		0	5.00
6.00	SWING BED - NF	0				0	6.00
200.00	TOTAL	0	72,247	85,720	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: 15-1311 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I | Date/Time Prepared: 5/29/2024 2:28 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 1000 SOUTH MAIN STREET	PO Box:			1.00
2.00	City: TIPTON	State: IN	Zip Code: 46072	County: TIPTON	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 TIPTON HOSPITAL	151311	99915	1	11/12/2005	N	O	P	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	IU HEALTH TIPTON HOSPITAL	15Z311	29020		11/12/2005	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									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: 1.00	To: 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: 15-1311 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I Date/Time Prepared: 5/29/2024 2:28 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

		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

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

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

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

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

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

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

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

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

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

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

		V	XIX	
		1.00	2.00	
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.06
	Rural Providers			
105.00	Does this hospital qualify as a CAH?	Y		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N		106.00
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N		107.00
107.01	If this facility is a REH (line 3, column 4, is "12"), is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no. (see instructions)			107.01
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1311 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I | Date/Time Prepared: 5/29/2024 2:28 pm

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	34,162	0	0	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	Y	5.00	122.00
123.00	Did the facility and/or its subproviders (if applicable) purchase professional services, e.g., legal, accounting, tax preparation, bookkeeping, payroll, and/or management/consulting services, from an unrelated organization? In column 1, enter "Y" for yes or "N" for no. If column 1 is "Y", were the majority of the expenses, i.e., greater than 50% of total professional services expenses, for services purchased from unrelated organizations located in a CBSA outside of the main hospital CBSA? In column 2, enter "Y" for yes or "N" for no.	Y	N	123.00
	Certified Transplant Center Information			
125.00	Does this facility operate a Medicare-certified transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare-certified kidney transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare-certified heart transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare-certified liver transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare-certified lung transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare-certified pancreas transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare-certified intestinal transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare-certified islet transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	Removed and reserved			133.00
134.00	If this is a hospital-based organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	15H059	140.00

	1.00	2.00	3.00	
	If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.			
141.00	Name: INDIANA UNIVERSITY HEALTH	Contractor's Name: WPS	Contractor's Number: 08101	141.00
142.00	Street: 340 WEST 10TH STREET	PO Box:		142.00
143.00	City: INDIANAPOLIS	State: IN	Zip Code: 46202	143.00

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

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

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

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

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

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

		1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act		
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.	Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)		168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)	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	21	171.00

		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	04/02/2024	Y	04/02/2024	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: 15-1311	Period: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part II Date/Time Prepared: 5/29/2024 2:28 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.	N	35.00

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-1311	Period: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part II Date/Time Prepared: 5/29/2024 2:28 pm

		3.00		
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	DIRECTOR OF GOVERNMENT PROGRAMS		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: 15-1311 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part I Date/Time Prepared: 5/29/2024 2:28 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	25	9,125	38,136.00	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)		25	9,125	38,136.00	0	7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		25	9,125	38,136.00	0	14.00
15.00	CAH visits					0	15.00
15.10	REH hours and visits				0.00	0	15.10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		25				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00
33.01	LTCH site neutral days and discharges						33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care	30.00	0	0		0	34.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1311 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part I | Date/Time Prepared: 5/29/2024 2:28 pm

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	850	8	1,589			1.00
2.00	HMO and other (see instructions)	485	64				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	111	0	111			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	29			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	961	8	1,729			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)	961	8	1,729	0.00	149.00	14.00
15.00	CAH visits	0	0	0			15.00
15.10	REH hours and visits	0	0	0			15.10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			1			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	149.00	27.00
28.00	Observation Bed Days		0	284			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: 15-1311 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part I Date/Time Prepared: 5/29/2024 2:28 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	239	2	436	1.00
2.00	HMO and other (see instructions)			133	12		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	239	2	436	14.00
15.00	CAH visits						15.00
15.10	REH hours and visits						15.10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care						34.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-1311 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-10 Parts I & II Date/Time Prepared: 5/29/2024 2:28 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)			0.287522	1.00
	Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid			4,737,285	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?				3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?				4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid			0	5.00
6.00	Medicaid charges			26,506,781	6.00
7.00	Medicaid cost (line 1 times line 6)			7,621,283	7.00
8.00	Difference between net revenue and costs for Medicaid program (see instructions)			2,883,998	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)			38,512	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)			173,713	14.00
15.00	State or local indigent care program cost (line 1 times line 14)			49,946	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (see instructions)			11,434	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)			2,895,432	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)	1,094,726	170,359	1,265,085	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	314,758	117,292	432,050	21.00
22.00	Payments received from patients for amounts previously written off as charity care	5,764	0	5,764	22.00
23.00	Cost of charity care (see instructions)	308,994	117,292	426,286	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)			74,483	25.01
26.00	Bad debt amount (see instructions)			2,417,170	26.00
27.00	Medicare reimbursable bad debts (see instructions)			546,322	27.00
27.01	Medicare allowable bad debts (see instructions)			840,496	27.01
28.00	Non-Medicare bad debt amount (see instructions)			1,576,674	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)			747,502	29.00
30.00	Cost of uncompensated care (line 23, col. 3, plus line 29)			1,173,788	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			4,069,220	31.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 15-1311	Period: From 01/01/2023 To 12/31/2023	Worksheet S-10 Parts I & II Date/Time Prepared: 5/29/2024 2:28 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: 15-1311 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A | Date/Time Prepared: 5/29/2024 2:28 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	795,248	795,248	1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - INTERES		0	0	513,352	513,352	1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	1,062,695	1,062,695	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	12,933	12,933	2,012,339	2,025,272	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	421,211	10,495,013	10,916,224	-1,118,709	9,797,515	5.00
7.00	00700	OPERATION OF PLANT	782,942	3,055,267	3,838,209	-172,357	3,665,852	7.00
7.01	00701	OPERATION OF PLANT - OFFSITE	0	0	0	0	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	74,169	74,169	0	74,169	8.00
9.00	00900	HOUSEKEEPING	504,541	401,272	905,813	-134,055	771,758	9.00
10.00	01000	DIETARY	361,887	378,923	740,810	-535,069	205,741	10.00
11.00	01100	CAFETERIA	0	0	0	434,485	434,485	11.00
13.00	01300	NURSING ADMINISTRATION	641,337	560,007	1,201,344	-370,284	831,060	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	10,776	10,776	331,729	342,505	14.00
15.00	01500	PHARMACY	765,171	5,686,090	6,451,261	-5,183,623	1,267,638	15.00
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,263,561	1,087,155	2,350,716	-329,447	2,021,269	30.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,041,763	3,162,702	4,204,465	-1,635,072	2,569,393	50.00
53.00	05300	ANESTHESIOLOGY	0	643,505	643,505	-8,988	634,517	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,145,056	718,478	1,863,534	-553,880	1,309,654	54.00
60.00	06000	LABORATORY	0	1,814,190	1,814,190	-30,656	1,783,534	60.00
65.00	06500	RESPIRATORY THERAPY	685,946	227,841	913,787	-155,552	758,235	65.00
66.00	06600	PHYSICAL THERAPY	803,034	486,040	1,289,074	-440,752	848,322	66.00
67.00	06700	OCCUPATIONAL THERAPY	203,953	40,238	244,191	17,386	261,577	67.00
68.00	06800	SPEECH PATHOLOGY	42,004	5,148	47,152	554	47,706	68.00
69.00	06900	ELECTROCARDIOLOGY	551,590	285,933	837,523	-161,859	675,664	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	251,455	251,455	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	646,073	646,073	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	4,169,102	4,169,102	73.00
73.01	03480	ONCOLOGY	160,759	76,123	236,882	-49,462	187,420	73.01
73.02	07301	BLOOD DISORDER DRUGS	0	0	0	1,091,193	1,091,193	73.02
76.00	03160	CARDIOPULMONARY	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	145,512	88,687	234,199	-65,513	168,686	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							
91.00	09100	EMERGENCY	1,151,243	2,116,448	3,267,691	-303,687	2,964,004	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
	OTHER REIMBURSABLE COST CENTERS							
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
	SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	10,671,510	31,426,938	42,098,448	76,646	42,175,094	118.00
	NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	64,036	55,009	119,045	-45,244	73,801	192.00
192.01	19201	OCCUPATIONAL MEDICINE	67,738	83,805	151,543	-31,402	120,141	192.01
192.02	19202	VACANT SPACE	0	0	0	0	0	192.02
200.00		TOTAL (SUM OF LINES 118 through 199)	10,803,284	31,565,752	42,369,036	0	42,369,036	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1311 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A | Date/Time Prepared: 5/29/2024 2:28 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	609,770	1,405,018	1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - INTERES	172,355	685,707	1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP	171,579	1,234,274	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-129,051	1,896,221	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-3,102,953	6,694,562	5.00
7.00	00700	OPERATION OF PLANT	492,176	4,158,028	7.00
7.01	00701	OPERATION OF PLANT - OFFSITE	0	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	74,169	8.00
9.00	00900	HOUSEKEEPING	-47,280	724,478	9.00
10.00	01000	DIETARY	-541	205,200	10.00
11.00	01100	CAFETERIA	0	434,485	11.00
13.00	01300	NURSING ADMINISTRATION	-5,260	825,800	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	342,505	14.00
15.00	01500	PHARMACY	14,384	1,282,022	15.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	-536,952	1,484,317	30.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	-463,250	2,106,143	50.00
53.00	05300	ANESTHESIOLOGY	-583,657	50,860	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	115,477	1,425,131	54.00
60.00	06000	LABORATORY	0	1,783,534	60.00
65.00	06500	RESPIRATORY THERAPY	0	758,235	65.00
66.00	06600	PHYSICAL THERAPY	0	848,322	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	261,577	67.00
68.00	06800	SPEECH PATHOLOGY	0	47,706	68.00
69.00	06900	ELECTROCARDIOLOGY	-87,045	588,619	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	251,455	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	646,073	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	4,169,102	73.00
73.01	03480	ONCOLOGY	0	187,420	73.01
73.02	07301	BLOOD DISORDER DRUGS	0	1,091,193	73.02
76.00	03160	CARDIOPULMONARY	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	-101	168,585	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			
91.00	09100	EMERGENCY	-22,633	2,941,371	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
		OTHER REIMBURSABLE COST CENTERS			
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	102.00
		SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-3,402,982	38,772,112	118.00
		NONREIMBURSABLE COST CENTERS			
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	73,801	192.00
192.01	19201	OCCUPATIONAL MEDICINE	0	120,141	192.01
192.02	19202	VACANT SPACE	0	0	192.02
200.00		TOTAL (SUM OF LINES 118 through 199)	-3,402,982	38,966,054	200.00

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - DEPRECIATION				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	571,019	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	1,060,374	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
	0		0	1,631,393	
	B - INTEREST				
1.00	CAP REL COSTS-BLDG & FIXT - INTERES	1.01	0	513,352	1.00
	0		0	513,352	
	D - EMPLOYEE BENEFITS				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	2,012,335	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
	0		0	2,012,335	
	E - CAFETERIA				
1.00	CAFETERIA	11.00	245,592	188,893	1.00
	0		245,592	188,893	
	F - MEDICAL SUPPLIES				
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	332,945	1.00
2.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	251,455	2.00
3.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	646,073	3.00
4.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	4	4.00
5.00	HOUSEKEEPING	9.00	0	261	5.00
6.00	DIETARY	10.00	0	14	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	NURSING ADMINISTRATION	13.00	0	107	10.00
11.00	SPEECH PATHOLOGY	68.00	0	4	11.00
12.00	ELECTROCARDIOLOGY	69.00	0	1,983	12.00
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
	0		0	1,232,846	
	G - DRUGS				
1.00	PHARMACY	15.00	0	82,684	1.00
2.00	DRUGS CHARGED TO PATIENTS	73.00	0	5,260,295	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

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	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
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
	0		0	5,342,979	
	H - ORTHOPEDIC CLERICAL STAFF				
1.00	OCCUPATIONAL THERAPY	67.00	40,027	0	1.00
2.00	SPEECH PATHOLOGY	68.00	1,959	0	2.00
	0		41,986	0	
	J - MAINTENANCE & LEASE EXPENSE				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	154,009	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	1,939	2.00
3.00	OPERATION OF PLANT	7.00	0	18,763	3.00
	0		0	174,711	
	L - PROPERTY INSURANCE				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	70,220	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	2,321	2.00
	0		0	72,541	
	N - INFUSION DRUGS				
1.00	BLOOD DISORDER DRUGS	73.02	0	1,091,193	1.00
	0		0	1,091,193	
500.00	Grand Total: Increases		287,578	12,260,243	500.00

RECLASSIFICATIONS | Provider CCN: 15-1311 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-6 | Date/Time Prepared: 5/29/2024 2:28 pm

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - DEPRECIATION						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	477,278	9		1.00
2.00	OPERATION OF PLANT	7.00	0	34,742	9		2.00
3.00	DIETARY	10.00	0	21,460	0		3.00
4.00	NURSING ADMINISTRATION	13.00	0	264,048	0		4.00
5.00	PHARMACY	15.00	0	39,972	0		5.00
6.00	ADULTS & PEDIATRICS	30.00	0	40,171	0		6.00
7.00	OPERATING ROOM	50.00	0	360,606	0		7.00
8.00	ANESTHESIOLOGY	53.00	0	8,988	0		8.00
9.00	RADIOLOGY-DIAGNOSTIC	54.00	0	207,985	0		9.00
10.00	RESPIRATORY THERAPY	65.00	0	13,673	0		10.00
11.00	PHYSICAL THERAPY	66.00	0	49,776	0		11.00
12.00	ELECTROCARDIOLOGY	69.00	0	51,166	0		12.00
13.00	ONCOLOGY	73.01	0	676	0		13.00
14.00	CARDIAC REHABILITATION	76.97	0	14,177	0		14.00
15.00	EMERGENCY	91.00	0	17,604	0		15.00
16.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	29,071	0		16.00
	0		0	1,631,393			
	B - INTEREST						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	513,352	11		1.00
	0		0	513,352			
	D - EMPLOYEE BENEFITS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	57,160	0		1.00
2.00	OPERATION OF PLANT	7.00	0	154,689	0		2.00
3.00	HOUSEKEEPING	9.00	0	134,316	0		3.00
4.00	DIETARY	10.00	0	79,138	0		4.00
5.00	NURSING ADMINISTRATION	13.00	0	106,343	0		5.00
6.00	PHARMACY	15.00	0	108,535	0		6.00
7.00	ADULTS & PEDIATRICS	30.00	0	230,431	0		7.00
8.00	OPERATING ROOM	50.00	0	193,422	0		8.00
9.00	RADIOLOGY-DIAGNOSTIC	54.00	0	257,701	0		9.00
10.00	RESPIRATORY THERAPY	65.00	0	115,077	0		10.00
11.00	PHYSICAL THERAPY	66.00	0	164,992	0		11.00
12.00	OCCUPATIONAL THERAPY	67.00	0	22,223	0		12.00
13.00	SPEECH PATHOLOGY	68.00	0	1,409	0		13.00
14.00	ELECTROCARDIOLOGY	69.00	0	88,625	0		14.00
15.00	ONCOLOGY	73.01	0	28,511	0		15.00
16.00	CARDIAC REHABILITATION	76.97	0	44,474	0		16.00
17.00	EMERGENCY	91.00	0	189,262	0		17.00
18.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	15,010	0		18.00
19.00	OCCUPATIONAL MEDICINE	192.01	0	21,017	0		19.00
	0		0	2,012,335			
	E - CAFETERIA						
1.00	DIETARY	10.00	245,592	188,893	0		1.00
	0		245,592	188,893			
	F - MEDICAL SUPPLIES						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	1,005	0		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	112	0		2.00
3.00	OPERATION OF PLANT	7.00	0	1,237	0		3.00
4.00		0.00	0	0	0		4.00
5.00	PHARMACY	15.00	0	1,986	0		5.00
6.00	ADULTS & PEDIATRICS	30.00	0	39,237	0		6.00
7.00	OPERATING ROOM	50.00	0	1,044,640	0		7.00
8.00	LABORATORY	60.00	0	30,656	0		8.00
9.00	RESPIRATORY THERAPY	65.00	0	26,059	0		9.00
10.00	PHYSICAL THERAPY	66.00	0	9,761	0		10.00
11.00	OCCUPATIONAL THERAPY	67.00	0	418	0		11.00
12.00		0.00	0	0	0		12.00
14.00	ONCOLOGY	73.01	0	10,000	0		14.00
15.00	CARDIAC REHABILITATION	76.97	0	6,837	0		15.00
16.00	EMERGENCY	91.00	0	55,744	0		16.00
17.00	OCCUPATIONAL MEDICINE	192.01	0	989	0		17.00
18.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	283	0		18.00
19.00	RADIOLOGY-DIAGNOSTIC	54.00	0	3,882	0		19.00
	0		0	1,232,846			
	G - DRUGS						
1.00	PHARMACY	15.00	0	5,115,814	0		1.00
2.00	OPERATION OF PLANT	7.00	0	452	0		2.00
3.00	ADULTS & PEDIATRICS	30.00	0	19,608	0		3.00
4.00	OPERATING ROOM	50.00	0	36,404	0		4.00
5.00	RADIOLOGY-DIAGNOSTIC	54.00	0	84,312	0		5.00
6.00	RESPIRATORY THERAPY	65.00	0	743	0		6.00
7.00	PHYSICAL THERAPY	66.00	0	406	0		7.00
8.00	ELECTROCARDIOLOGY	69.00	0	24,051	0		8.00

RECLASSIFICATIONS | Provider CCN: 15-1311 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-6 | Date/Time Prepared: 5/29/2024 2:28 pm

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
9.00	ONCOLOGY	73.01	0	10,275	0		9.00
10.00	CARDIAC REHABILITATION	76.97	0	25	0		10.00
11.00	EMERGENCY	91.00	0	41,077	0		11.00
12.00	OCCUPATIONAL MEDICINE	192.01	0	9,396	0		12.00
14.00	ADMINISTRATIVE & GENERAL	5.00	0	205	0		14.00
15.00	CENTRAL SERVICES & SUPPLY	14.00	0	211	0		15.00
	0		0	5,342,979			
	H - ORTHOPEDIC CLERICAL STAFF						
1.00	PHYSICAL THERAPY	66.00	41,986	0	0		1.00
2.00		0.00	0	0	0		2.00
	0		41,986	0			
	J - MAINTENANCE & LEASE EXPENSE						
1.00	PHYSICAL THERAPY	66.00	0	173,831	10		1.00
2.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	880	0		2.00
3.00		0.00	0	0	0		3.00
	0		0	174,711			
	L - PROPERTY INSURANCE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	72,541	12		1.00
2.00		0.00	0	0	12		2.00
	0		0	72,541			
	N - INFUSION DRUGS						
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	1,091,193	0		1.00
	0		0	1,091,193			
500.00	Grand Total: Decreases		287,578	12,260,243			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1311 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-7 Part I | Date/Time Prepared: 5/29/2024 2:28 pm

		Beginning Balances	Acquisitions Purchases	Donation	Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	0	0	0	0	0	1.00
2.00	Land Improvements	0	0	0	0	0	2.00
3.00	Buildings and Fixtures	0	0	0	0	0	3.00
4.00	Building Improvements	3,139,179	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	14,011,166	1,034,548	0	1,034,548	340,180	6.00
7.00	HIT designated Assets	755,571	0	0	0	5,460	7.00
8.00	Subtotal (sum of lines 1-7)	17,905,916	1,034,548	0	1,034,548	345,640	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	17,905,916	1,034,548	0	1,034,548	345,640	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	0	0	1.00
2.00	Land Improvements	0	0	2.00
3.00	Buildings and Fixtures	0	0	3.00
4.00	Building Improvements	3,139,179	377,123	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	14,705,534	8,972,464	6.00
7.00	HIT designated Assets	750,111	750,111	7.00
8.00	Subtotal (sum of lines 1-7)	18,594,824	10,099,698	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	18,594,824	10,099,698	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1311 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-7 Part II Date/Time Prepared: 5/29/2024 2:28 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
1.01	CAP REL COSTS-BLDG & FIXT - INTERES	0	0	0	0	0	1.01
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
1.01	CAP REL COSTS-BLDG & FIXT - INTERES	0	0	1.01
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: 15-1311	Period: From 01/01/2023 To 12/31/2023	Worksheet A-7 Part III Date/Time Prepared: 5/29/2024 2:28 pm

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	3,889,290	0	3,889,290	0.209160	0	1.00
1.01	CAP REL COSTS-BLDG & FIXT - INTERES	0	0	0	0.000000	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	14,705,534	0	14,705,534	0.790840	0	2.00
3.00	Total (sum of lines 1-2)	18,594,824	0	18,594,824	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	1,180,789	154,009	1.00
1.01	CAP REL COSTS-BLDG & FIXT - INTERES	0	0	0	172,355	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	1,231,953	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	2,585,097	154,009	3.00

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	70,220	0	0	1,405,018	1.00
1.01	CAP REL COSTS-BLDG & FIXT - INTERES	513,352	0	0	0	685,707	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	2,321	0	0	1,234,274	2.00
3.00	Total (sum of lines 1-2)	513,352	72,541	0	0	3,324,999	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1311 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-8 | Date/Time Prepared: 5/29/2024 2:28 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
				Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
1.01	Investment income - CAP REL COSTS-BLDG & FIXT - INTERES (chapter 2)	B	-2,664,278	CAP REL COSTS-BLDG & FIXT - INTERES	1.01	9	1.01
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	-1,673,995			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	4,883,060			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests		0		0.00	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	B	-102,045	PHARMACY	15.00	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	A	779,048	CAP REL COSTS-BLDG & FIXT	1.00	9	26.00
26.01	Depreciation - CAP REL COSTS-BLDG & FIXT - INTERES		0	CAP REL COSTS-BLDG & FIXT - INTERES	1.01	0	26.01
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP	A	32,696	CAP REL COSTS-MVBLE EQUIP	2.00	9	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1311 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-8 | Date/Time Prepared: 5/29/2024 2:28 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	
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	MISCELLANEOUS INCOME	B	-87,117	ADMINISTRATIVE & GENERAL	5.00	0	33.00
33.01	INVESTMENT FEES	A	8,002	ADMINISTRATIVE & GENERAL	5.00	0	33.01
33.02	MISCELLANEOUS INCOME	B	-47,280	HOUSEKEEPING	9.00	0	33.02
33.03	MISCELLANEOUS INCOME	B	0	NURSING ADMINISTRATION	13.00	0	33.03
33.04	MISCELLANEOUS INCOME	B	111	PHARMACY	15.00	0	33.04
33.05	MISCELLANEOUS INCOME	B	-60	RADIOLOGY-DIAGNOSTIC	54.00	0	33.05
33.06	MISCELLANEOUS INCOME	B	-19,542	ELECTROCARDIOLOGY	69.00	0	33.06
33.07	MEDICAID HOSPITAL ASSESSMENT FEE	A	-2,308,969	ADMINISTRATIVE & GENERAL	5.00	0	33.07
33.08	ASSISTED LIVING DEPRECIATION - BLDG	A	-125,777	CAP REL COSTS-BLDG & FIXT	1.00	9	33.08
33.09	PATIENT PHONES - SALARY	A	-3,296	ADMINISTRATIVE & GENERAL	5.00	0	33.09
33.10	PATIENT PHONES - BENEFITS	A	-507	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.10
33.11	EMPLOYEE BENEFITS	A	-2,012,335	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.11
33.12	LEASE DEPRECIATION - CARRY FORWARD A	A	284	CAP REL COSTS-BLDG & FIXT	1.00	9	33.12
33.13	EQUIPMENT DEPRECIATION - CARRY FORWA	A	-3,456	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.13
33.14	RECRUITING	A	0	OPERATING ROOM	50.00	0	33.14
33.15	MARKETING	A	-56,884	ADMINISTRATIVE & GENERAL	5.00	0	33.15
33.16	MARKETING	A	-541	DIETARY	10.00	0	33.16
33.17	MARKETING	A	-101	CARDIAC REHABILITATION	76.97	0	33.17
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-3,402,982				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: 15-1311 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-8-1 | Date/Time Prepared: 5/29/2024 2:28 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	128,107	171,892	1.00
2.00	1.01	CAP REL COSTS-BLDG & FIXT -	HOME OFFICE ALLOCATION	2,836,633	0	2.00
3.00	2.00	CAP REL COSTS-MVBLE EQUIP	HOME OFFICE ALLOCATION	142,339	0	3.00
3.01	4.00	EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE ALLOCATION	1,885,611	1,820	3.01
3.02	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE ALLOCATION	6,150,831	6,971,017	3.02
3.03	7.00	OPERATION OF PLANT	HOME OFFICE ALLOCATION	171,892	0	3.03
3.04	5.00	ADMINISTRATIVE & GENERAL	RELATED PARTY	293,623	128,126	3.04
3.05	7.00	OPERATION OF PLANT	RELATED PARTY	331,196	10,912	3.05
3.06	13.00	NURSING ADMINISTRATION	RELATED PARTY	0	5,260	3.06
3.07	15.00	PHARMACY	RELATED PARTY	243,347	127,029	3.07
3.08	54.00	RADIOLOGY-DIAGNOSTIC	RELATED PARTY	125,076	9,539	3.08
3.09	4.00	EMPLOYEE BENEFITS DEPARTMENT	SHARED EMPLOYEES	2,548	2,548	3.09
3.10	5.00	ADMINISTRATIVE & GENERAL	SHARED EMPLOYEES	162,281	162,281	3.10
3.11	7.00	OPERATION OF PLANT	SHARED EMPLOYEES	27,094	27,094	3.11
3.12	13.00	NURSING ADMINISTRATION	SHARED EMPLOYEES	46,176	46,176	3.12
3.13	30.00	ADULTS & PEDIATRICS	SHARED EMPLOYEES	543,979	543,979	3.13
3.14	50.00	OPERATING ROOM	SHARED EMPLOYEES	166,250	166,250	3.14
3.15	53.00	ANESTHESIOLOGY	SHARED EMPLOYEES	634,517	634,517	3.15
3.16	54.00	RADIOLOGY-DIAGNOSTIC	SHARED EMPLOYEES	21,038	21,038	3.16
3.17	60.00	LABORATORY	SHARED EMPLOYEES	1,667,107	1,667,107	3.17
3.18	69.00	ELECTROCARDIOLOGY	SHARED EMPLOYEES	261,854	261,854	3.18
3.19	91.00	EMERGENCY	SHARED EMPLOYEES	1,340,638	1,340,638	3.19
3.20	192.01	OCCUPATIONAL MEDICINE	SHARED EMPLOYEES	26,674	26,674	3.20
4.00	0.00			0	0	4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			17,208,811	12,325,751	5.00

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

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

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

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

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

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

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

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

Provider CCN: 15-1311 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-8-1 | Date/Time Prepared: 5/29/2024 2:28 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	-43,785	9	1.00
2.00	2,836,633	9	2.00
3.00	142,339	9	3.00
3.01	1,883,791	0	3.01
3.02	-820,186	0	3.02
3.03	171,892	0	3.03
3.04	165,497	0	3.04
3.05	320,284	0	3.05
3.06	-5,260	0	3.06
3.07	116,318	0	3.07
3.08	115,537	0	3.08
3.09	0	0	3.09
3.10	0	0	3.10
3.11	0	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
3.20	0	0	3.20
4.00	0	0	4.00
5.00	4,883,060		5.00

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

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

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

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

	Type of Business	
6.00	HOME OFFICE	6.00
7.00	HEALTHCARE	7.00
8.00	HEALTHCARE	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: 15-1311 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-8-2 | Date/Time Prepared: 5/29/2024 2:28 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	536,952	536,952	0	0	0	1.00
2.00	50.00	OPERATING ROOM	463,250	463,250	0	0	0	2.00
3.00	53.00	ANESTHESIOLOGY	583,657	583,657	0	0	0	3.00
4.00	69.00	ELECTROCARDIOLOGY	67,503	67,503	0	0	0	4.00
5.00	91.00	EMERGENCY	1,340,638	22,633	1,318,005	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			2,992,000	1,673,995	1,318,005		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	50.00	OPERATING ROOM	0	0	0	0	0	2.00
3.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	3.00
4.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	4.00
5.00	91.00	EMERGENCY	0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
	1.00	2.00	15.00	16.00	17.00	18.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	536,952	1.00
2.00	50.00	OPERATING ROOM	0	0	0	463,250	2.00
3.00	53.00	ANESTHESIOLOGY	0	0	0	583,657	3.00
4.00	69.00	ELECTROCARDIOLOGY	0	0	0	67,503	4.00
5.00	91.00	EMERGENCY	0	0	0	22,633	5.00
6.00	0.00		0	0	0	0	6.00
7.00	0.00		0	0	0	0	7.00
8.00	0.00		0	0	0	0	8.00
9.00	0.00		0	0	0	0	9.00
10.00	0.00		0	0	0	0	10.00
200.00			0	0	0	1,673,995	200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1311 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I | Date/Time Prepared: 5/29/2024 2:28 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT	
				BLDG & FIXT	BLDG & FIXT - INTERES	MVBLE EQUIP		
			0	1.00	1.01	2.00	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	1,405,018	1,405,018				1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - INTERES	685,707	0	685,707			1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP	1,234,274			1,234,274		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,896,221	6,083	3,472	5,343	1,911,119	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	6,694,562	87,150	49,275	76,559	74,513	5.00
7.00	00700	OPERATION OF PLANT	4,158,028	338,183	169,988	297,088	138,504	7.00
7.01	00701	OPERATION OF PLANT - OFFSITE	0	0	0	0	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	74,169	22,387	12,780	19,666	0	8.00
9.00	00900	HOUSEKEEPING	724,478	13,364	7,629	11,740	89,254	9.00
10.00	01000	DIETARY	205,200	18,854	10,763	16,563	20,573	10.00
11.00	01100	CAFETERIA	434,485	39,813	22,728	34,974	43,446	11.00
13.00	01300	NURSING ADMINISTRATION	825,800	23,076	13,174	20,272	113,454	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	342,505	28,957	16,531	25,438	0	14.00
15.00	01500	PHARMACY	1,282,022	15,907	9,081	13,974	135,360	15.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,484,317	163,814	93,517	143,906	223,523	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,106,143	168,621	96,262	148,130	184,290	50.00
53.00	05300	ANESTHESIOLOGY	50,860	3,184	1,818	2,797	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,425,131	87,352	49,867	76,737	202,563	54.00
60.00	06000	LABORATORY	1,783,534	35,806	20,441	31,455	0	60.00
65.00	06500	RESPIRATORY THERAPY	758,235	2,090	1,193	1,836	121,345	65.00
66.00	06600	PHYSICAL THERAPY	848,322	38,872	6,392	34,148	134,631	66.00
67.00	06700	OCCUPATIONAL THERAPY	261,577	10,688	1,758	9,389	43,161	67.00
68.00	06800	SPEECH PATHOLOGY	47,706	523	88	459	7,777	68.00
69.00	06900	ELECTROCARDIOLOGY	588,619	22,958	13,106	20,168	97,577	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	251,455	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	646,073	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,169,102	0	0	0	0	73.00
73.01	03480	ONCOLOGY	187,420	13,949	7,963	12,254	28,439	73.01
73.02	07301	BLOOD DISORDER DRUGS	1,091,193	0	0	0	0	73.02
76.00	03160	CARDIOPULMONARY	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	168,585	24,129	13,774	21,196	25,741	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						
91.00	09100	EMERGENCY	2,941,371	98,187	56,052	86,254	203,657	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	38,772,112	1,263,947	677,652	1,110,346	1,887,808	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	73,801	126,962	0	111,533	11,328	192.00
192.01	19201	OCCUPATIONAL MEDICINE	120,141	14,109	8,055	12,395	11,983	192.01
192.02	19202	VACANT SPACE	0	0	0	0	0	192.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	38,966,054	1,405,018	685,707	1,234,274	1,911,119	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1311 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I Date/Time Prepared: 5/29/2024 2:28 pm

		Cost Center Description	Subtotal	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	OPERATION OF PLANT - OFFSITE	LAUNDRY & LINEN SERVICE	
			4A	5.00	7.00	7.01	8.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - INTERES						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	6,982,059	6,982,059				5.00
7.00	00700	OPERATION OF PLANT	5,101,791	1,113,703	6,215,494			7.00
7.01	00701	OPERATION OF PLANT - OFFSITE	0	0	0	0		7.01
8.00	00800	LAUNDRY & LINEN SERVICE	129,002	28,161	171,574	0	328,737	8.00
9.00	00900	HOUSEKEEPING	846,465	184,782	102,421	0	0	9.00
10.00	01000	DIETARY	271,953	59,367	144,500	0	0	10.00
11.00	01100	CAFETERIA	575,446	125,619	305,128	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	995,776	217,377	176,861	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	413,431	90,252	221,930	0	0	14.00
15.00	01500	PHARMACY	1,456,344	317,918	121,912	0	0	15.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,109,077	460,409	1,255,488	0	328,737	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,703,446	590,160	1,292,333	0	0	50.00
53.00	05300	ANESTHESIOLOGY	58,659	12,805	24,404	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,841,650	402,030	669,476	0	0	54.00
60.00	06000	LABORATORY	1,871,236	408,489	274,423	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	884,699	193,129	16,020	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,062,365	231,913	85,814	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	326,573	71,291	23,603	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	56,553	12,345	1,175	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	742,428	162,071	175,953	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	251,455	54,892	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	646,073	141,037	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,169,102	910,111	0	0	0	73.00
73.01	03480	ONCOLOGY	250,025	54,580	106,907	0	0	73.01
73.02	07301	BLOOD DISORDER DRUGS	1,091,193	238,206	0	0	0	73.02
76.00	03160	CARDIOPULMONARY	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	253,425	55,322	184,924	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						
91.00	09100	EMERGENCY	3,385,521	739,056	752,513	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0					92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	38,475,747	6,875,025	6,107,359	0	328,737	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	323,624	70,647	0	0	0	192.00
192.01	19201	OCCUPATIONAL MEDICINE	166,683	36,387	108,135	0	0	192.01
192.02	19202	VACANT SPACE	0	0	0	0	0	192.02
200.00		Cross Foot Adjustments	0					200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	38,966,054	6,982,059	6,215,494	0	328,737	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1311 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I Date/Time Prepared: 5/29/2024 2:28 pm

		Cost Center Description	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			9.00	10.00	11.00	13.00	14.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - INTERES						1.01
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	OPERATION OF PLANT - OFFSITE						7.01
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	1,133,668					9.00
10.00	01000	DIETARY	22,791	498,611				10.00
11.00	01100	CAFETERIA	48,125	0	1,054,318			11.00
13.00	01300	NURSING ADMINISTRATION	27,895	0	53,667	1,471,576		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	35,003	0	0	0	760,616	14.00
15.00	01500	PHARMACY	19,228	0	71,842	0	1,487	15.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	198,017	498,379	159,196	624,126	20,458	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	203,829	0	123,035	340,165	149,382	50.00
53.00	05300	ANESTHESIOLOGY	3,849	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	105,590	0	125,700	10,810	4,287	54.00
60.00	06000	LABORATORY	43,282	0	88,780	0	16,454	60.00
65.00	06500	RESPIRATORY THERAPY	2,527	0	68,226	0	15,306	65.00
66.00	06600	PHYSICAL THERAPY	46,988	0	88,875	0	484	66.00
67.00	06700	OCCUPATIONAL THERAPY	12,920	0	25,406	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	632	0	4,472	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	27,752	0	55,856	47,562	1,535	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	145,573	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	374,025	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	03480	ONCOLOGY	16,861	0	20,553	65,407	3,290	73.01
73.02	07301	BLOOD DISORDER DRUGS	0	0	0	0	0	73.02
76.00	03160	CARDIOPULMONARY	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	29,166	0	18,079	43,208	144	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						
91.00	09100	EMERGENCY	118,687	232	130,553	328,246	27,388	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	963,142	498,611	1,034,240	1,459,524	759,813	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	153,471	0	9,325	0	167	192.00
192.01	19201	OCCUPATIONAL MEDICINE	17,055	0	10,753	12,052	636	192.01
192.02	19202	VACANT SPACE	0	0	0	0	0	192.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,133,668	498,611	1,054,318	1,471,576	760,616	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1311 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I | Date/Time Prepared: 5/29/2024 2:28 pm

		Cost Center Description	PHARMACY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			15.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - INTERES						1.01
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	OPERATION OF PLANT - OFFSITE						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	1,988,731					15.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,893	5,659,780	0	5,659,780		30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,106	5,408,456	0	5,408,456		50.00
53.00	05300	ANESTHESIOLOGY	0	99,717	0	99,717		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,831	3,161,374	0	3,161,374		54.00
60.00	06000	LABORATORY	0	2,702,664	0	2,702,664		60.00
65.00	06500	RESPIRATORY THERAPY	0	1,179,907	0	1,179,907		65.00
66.00	06600	PHYSICAL THERAPY	0	1,516,439	0	1,516,439		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	459,793	0	459,793		67.00
68.00	06800	SPEECH PATHOLOGY	0	75,177	0	75,177		68.00
69.00	06900	ELECTROCARDIOLOGY	525	1,213,682	0	1,213,682		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	451,920	0	451,920		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,161,135	0	1,161,135		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,551,985	6,631,198	0	6,631,198		73.00
73.01	03480	ONCOLOGY	3,064	520,687	0	520,687		73.01
73.02	07301	BLOOD DISORDER DRUGS	406,206	1,735,605	0	1,735,605		73.02
76.00	03160	CARDIOPULMONARY	0	0	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	0	584,268	0	584,268		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						
91.00	09100	EMERGENCY	13,121	5,495,317	0	5,495,317		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0			92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0		102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,988,731	38,057,119	0	38,057,119		118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	557,234	0	557,234		192.00
192.01	19201	OCCUPATIONAL MEDICINE	0	351,701	0	351,701		192.01
192.02	19202	VACANT SPACE	0	0	0	0		192.02
200.00		Cross Foot Adjustments		0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	1,988,731	38,966,054	0	38,966,054		202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-1311 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II | Date/Time Prepared: 5/29/2024 2:28 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	BLDG & FIXT - INTERES	MVBLE EQUIP	Subtotal	
			0	1.00	1.01	2.00	2A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - INTERES						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	6,083	3,472	5,343	14,898	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	87,150	49,275	76,559	212,984	5.00
7.00	00700	OPERATION OF PLANT	0	338,183	169,988	297,088	805,259	7.00
7.01	00701	OPERATION OF PLANT - OFFSITE	0	0	0	0	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	22,387	12,780	19,666	54,833	8.00
9.00	00900	HOUSEKEEPING	0	13,364	7,629	11,740	32,733	9.00
10.00	01000	DIETARY	0	18,854	10,763	16,563	46,180	10.00
11.00	01100	CAFETERIA	0	39,813	22,728	34,974	97,515	11.00
13.00	01300	NURSING ADMINISTRATION	0	23,076	13,174	20,272	56,522	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	28,957	16,531	25,438	70,926	14.00
15.00	01500	PHARMACY	0	15,907	9,081	13,974	38,962	15.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	163,814	93,517	143,906	401,237	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	168,621	96,262	148,130	413,013	50.00
53.00	05300	ANESTHESIOLOGY	0	3,184	1,818	2,797	7,799	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	87,352	49,867	76,737	213,956	54.00
60.00	06000	LABORATORY	0	35,806	20,441	31,455	87,702	60.00
65.00	06500	RESPIRATORY THERAPY	0	2,090	1,193	1,836	5,119	65.00
66.00	06600	PHYSICAL THERAPY	0	38,872	6,392	34,148	79,412	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	10,688	1,758	9,389	21,835	67.00
68.00	06800	SPEECH PATHOLOGY	0	523	88	459	1,070	68.00
69.00	06900	ELECTROCARDIOLOGY	0	22,958	13,106	20,168	56,232	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	03480	ONCOLOGY	0	13,949	7,963	12,254	34,166	73.01
73.02	07301	BLOOD DISORDER DRUGS	0	0	0	0	0	73.02
76.00	03160	CARDIOPULMONARY	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	24,129	13,774	21,196	59,099	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						
91.00	09100	EMERGENCY	0	98,187	56,052	86,254	240,493	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	1,263,947	677,652	1,110,346	3,051,945	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	126,962	0	111,533	238,495	192.00
192.01	19201	OCCUPATIONAL MEDICINE	0	14,109	8,055	12,395	34,559	192.01
192.02	19202	VACANT SPACE	0	0	0	0	0	192.02
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	1,405,018	685,707	1,234,274	3,324,999	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1311 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II Date/Time Prepared: 5/29/2024 2:28 pm

		Cost Center Description	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	OPERATION OF PLANT - OFFSITE	LAUNDRY & LINEN SERVICE	
			4.00	5.00	7.00	7.01	8.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - INTERES						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	14,898					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	581	213,565				5.00
7.00	00700	OPERATION OF PLANT	1,080	34,073	840,412			7.00
7.01	00701	OPERATION OF PLANT - OFFSITE	0	0	0	0		7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	861	23,199	0	78,893	8.00
9.00	00900	HOUSEKEEPING	696	5,652	13,849	0	0	9.00
10.00	01000	DIETARY	160	1,816	19,538	0	0	10.00
11.00	01100	CAFETERIA	339	3,842	41,257	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	884	6,649	23,914	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	2,760	30,008	0	0	14.00
15.00	01500	PHARMACY	1,055	9,724	16,484	0	0	15.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,742	14,082	169,758	0	78,893	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,437	18,051	174,740	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	392	3,300	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,579	12,297	90,521	0	0	54.00
60.00	06000	LABORATORY	0	12,494	37,105	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	946	5,907	2,166	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,049	7,093	11,603	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	336	2,181	3,191	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	61	378	159	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	761	4,957	23,791	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	1,679	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	4,314	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	27,837	0	0	0	73.00
73.01	03480	ONCOLOGY	222	1,669	14,455	0	0	73.01
73.02	07301	BLOOD DISORDER DRUGS	0	7,286	0	0	0	73.02
76.00	03160	CARDIOPULMONARY	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	201	1,692	25,004	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						
91.00	09100	EMERGENCY	1,588	22,605	101,749	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	14,717	210,291	825,791	0	78,893	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	88	2,161	0	0	0	192.00
192.01	19201	OCCUPATIONAL MEDICINE	93	1,113	14,621	0	0	192.01
192.02	19202	VACANT SPACE	0	0	0	0	0	192.02
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)	14,898	213,565	840,412	0	78,893	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1311 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II Date/Time Prepared: 5/29/2024 2:28 pm

		Cost Center Description	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			9.00	10.00	11.00	13.00	14.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - INTERES						1.01
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	OPERATION OF PLANT - OFFSITE						7.01
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	52,930					9.00
10.00	01000	DIETARY	1,064	68,758				10.00
11.00	01100	CAFETERIA	2,247	0	145,200			11.00
13.00	01300	NURSING ADMINISTRATION	1,302	0	7,391	96,662		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,634	0	0	0	105,328	14.00
15.00	01500	PHARMACY	898	0	9,894	0	206	15.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,245	68,726	21,924	40,997	2,833	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	9,518	0	16,944	22,344	20,686	50.00
53.00	05300	ANESTHESIOLOGY	180	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,930	0	17,311	710	594	54.00
60.00	06000	LABORATORY	2,021	0	12,227	0	2,279	60.00
65.00	06500	RESPIRATORY THERAPY	118	0	9,396	0	2,119	65.00
66.00	06600	PHYSICAL THERAPY	2,194	0	12,240	0	67	66.00
67.00	06700	OCCUPATIONAL THERAPY	603	0	3,499	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	29	0	616	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,296	0	7,692	3,124	213	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	20,159	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	51,792	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	03480	ONCOLOGY	787	0	2,831	4,296	456	73.01
73.02	07301	BLOOD DISORDER DRUGS	0	0	0	0	0	73.02
76.00	03160	CARDIOPULMONARY	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	1,362	0	2,490	2,838	20	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						
91.00	09100	EMERGENCY	5,541	32	17,980	21,561	3,793	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	44,969	68,758	142,435	95,870	105,217	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	7,165	0	1,284	0	23	192.00
192.01	19201	OCCUPATIONAL MEDICINE	796	0	1,481	792	88	192.01
192.02	19202	VACANT SPACE	0	0	0	0	0	192.02
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)	52,930	68,758	145,200	96,662	105,328	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1311 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II Date/Time Prepared: 5/29/2024 2:28 pm

		Cost Center Description	PHARMACY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			15.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - INTERES						1.01
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	OPERATION OF PLANT - OFFSITE						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	77,223					15.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	229	809,666	0	809,666		30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	237	676,970	0	676,970		50.00
53.00	05300	ANESTHESIOLOGY	0	11,671	0	11,671		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	71	341,969	0	341,969		54.00
60.00	06000	LABORATORY	0	153,828	0	153,828		60.00
65.00	06500	RESPIRATORY THERAPY	0	25,771	0	25,771		65.00
66.00	06600	PHYSICAL THERAPY	0	113,658	0	113,658		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	31,645	0	31,645		67.00
68.00	06800	SPEECH PATHOLOGY	0	2,313	0	2,313		68.00
69.00	06900	ELECTROCARDIOLOGY	20	98,086	0	98,086		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	21,838	0	21,838		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	56,106	0	56,106		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	60,265	88,102	0	88,102		73.00
73.01	03480	ONCOLOGY	119	59,001	0	59,001		73.01
73.02	07301	BLOOD DISORDER DRUGS	15,773	23,059	0	23,059		73.02
76.00	03160	CARDIOPULMONARY	0	0	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	0	92,706	0	92,706		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						
91.00	09100	EMERGENCY	509	415,851	0	415,851		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0			92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0		102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	77,223	3,022,240	0	3,022,240		118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	249,216	0	249,216		192.00
192.01	19201	OCCUPATIONAL MEDICINE	0	53,543	0	53,543		192.01
192.02	19202	VACANT SPACE	0	0	0	0		192.02
200.00		Cross Foot Adjustments		0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	77,223	3,324,999	0	3,324,999		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1311 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/29/2024 2:28 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	BLDG & FIXT - INTERES (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	
			1.00	1.01	2.00	4.00	5A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	201,652					1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - INTERES	0	172,392				1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP			201,652			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	873	873	873	10,803,284		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	12,508	12,388	12,508	421,211	-6,982,059	5.00
7.00	00700	OPERATION OF PLANT	48,537	42,736	48,537	782,942	0	7.00
7.01	00701	OPERATION OF PLANT - OFFSITE	0	0	0	0	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	3,213	3,213	3,213	0	0	8.00
9.00	00900	HOUSEKEEPING	1,918	1,918	1,918	504,541	0	9.00
10.00	01000	DIETARY	2,706	2,706	2,706	116,295	0	10.00
11.00	01100	CAFETERIA	5,714	5,714	5,714	245,592	0	11.00
13.00	01300	NURSING ADMINISTRATION	3,312	3,312	3,312	641,337	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	4,156	4,156	4,156	0	0	14.00
15.00	01500	PHARMACY	2,283	2,283	2,283	765,171	0	15.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	23,511	23,511	23,511	1,263,561	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	24,201	24,201	24,201	1,041,763	0	50.00
53.00	05300	ANESTHESIOLOGY	457	457	457	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	12,537	12,537	12,537	1,145,056	0	54.00
60.00	06000	LABORATORY	5,139	5,139	5,139	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	300	300	300	685,946	0	65.00
66.00	06600	PHYSICAL THERAPY	5,579	1,607	5,579	761,048	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,534	442	1,534	243,980	0	67.00
68.00	06800	SPEECH PATHOLOGY	75	22	75	43,963	0	68.00
69.00	06900	ELECTROCARDIOLOGY	3,295	3,295	3,295	551,590	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	03480	ONCOLOGY	2,002	2,002	2,002	160,759	0	73.01
73.02	07301	BLOOD DISORDER DRUGS	0	0	0	0	0	73.02
76.00	03160	CARDIOPULMONARY	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	3,463	3,463	3,463	145,512	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						
91.00	09100	EMERGENCY	14,092	14,092	14,092	1,151,243	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	181,405	170,367	181,405	10,671,510	-6,982,059	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	18,222	0	18,222	64,036	0	192.00
192.01	19201	OCCUPATIONAL MEDICINE	2,025	2,025	2,025	67,738	0	192.01
192.02	19202	VACANT SPACE	0	0	0	0	0	192.02
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)	1,405,018	685,707	1,234,274	1,911,119		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	6.967538	3.977603	6.120812	0.176902		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)				14,898		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)				0.001379		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: 15-1311 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/29/2024 2:28 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	OPERATION OF PLANT - OFFSITE (SQUARE FEET)	LAUNDRY & LINEN SERVICE (TOTAL PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	
			5.00	7.00	7.01	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - INTERES						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	31,983,995					5.00
7.00	00700	OPERATION OF PLANT	5,101,791	116,395				7.00
7.01	00701	OPERATION OF PLANT - OFFSITE	0	0	23,339			7.01
8.00	00800	LAUNDRY & LINEN SERVICE	129,002	3,213	0	1,589		8.00
9.00	00900	HOUSEKEEPING	846,465	1,918	0	0	134,603	9.00
10.00	01000	DIETARY	271,953	2,706	0	0	2,706	10.00
11.00	01100	CAFETERIA	575,446	5,714	0	0	5,714	11.00
13.00	01300	NURSING ADMINISTRATION	995,776	3,312	0	0	3,312	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	413,431	4,156	0	0	4,156	14.00
15.00	01500	PHARMACY	1,456,344	2,283	0	0	2,283	15.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,109,077	23,511	0	1,589	23,511	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,703,446	24,201	0	0	24,201	50.00
53.00	05300	ANESTHESIOLOGY	58,659	457	0	0	457	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,841,650	12,537	0	0	12,537	54.00
60.00	06000	LABORATORY	1,871,236	5,139	0	0	5,139	60.00
65.00	06500	RESPIRATORY THERAPY	884,699	300	0	0	300	65.00
66.00	06600	PHYSICAL THERAPY	1,062,365	1,607	3,972	0	5,579	66.00
67.00	06700	OCCUPATIONAL THERAPY	326,573	442	1,092	0	1,534	67.00
68.00	06800	SPEECH PATHOLOGY	56,553	22	53	0	75	68.00
69.00	06900	ELECTROCARDIOLOGY	742,428	3,295	0	0	3,295	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	251,455	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	646,073	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,169,102	0	0	0	0	73.00
73.01	03480	ONCOLOGY	250,025	2,002	0	0	2,002	73.01
73.02	07301	BLOOD DISORDER DRUGS	1,091,193	0	0	0	0	73.02
76.00	03160	CARDIOPULMONARY	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	253,425	3,463	0	0	3,463	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						
91.00	09100	EMERGENCY	3,385,521	14,092	0	0	14,092	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	31,493,688	114,370	5,117	1,589	114,356	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	323,624	0	18,222	0	18,222	192.00
192.01	19201	OCCUPATIONAL MEDICINE	166,683	2,025	0	0	2,025	192.01
192.02	19202	VACANT SPACE	0	0	0	0	0	192.02
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)	6,982,059	6,215,494	0	328,737	1,133,668	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.218299	53.400009	0.000000	206.882945	8.422309	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	213,565	840,412	0	78,893	52,930	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.006677	7.220345	0.000000	49.649465	0.393230	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: 15-1311 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/29/2024 2:28 pm

		Cost Center Description	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (DIRECT NURSING HOURS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
			10.00	11.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - INTERES						1.01
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	OPERATION OF PLANT - OFFSITE						7.01
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	6,442					10.00
11.00	01100	CAFETERIA	0	11,080				11.00
13.00	01300	NURSING ADMINISTRATION	0	564	88,892			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	1,313,848		14.00
15.00	01500	PHARMACY	0	755	0	2,568	5,342,335	15.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,439	1,673	37,701	35,338	15,831	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	1,293	20,548	258,035	16,402	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,321	653	7,405	4,919	54.00
60.00	06000	LABORATORY	0	933	0	28,422	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	717	0	26,438	0	65.00
66.00	06600	PHYSICAL THERAPY	0	934	0	836	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	267	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	47	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	587	2,873	2,651	1,410	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	251,455	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	646,073	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	4,169,102	73.00
73.01	03480	ONCOLOGY	0	216	3,951	5,683	8,232	73.01
73.02	07301	BLOOD DISORDER DRUGS	0	0	0	0	1,091,193	73.02
76.00	03160	CARDIOPULMONARY	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	190	2,610	248	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						
91.00	09100	EMERGENCY	3	1,372	19,828	47,309	35,246	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	6,442	10,869	88,164	1,312,461	5,342,335	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	98	0	289	0	192.00
192.01	19201	OCCUPATIONAL MEDICINE	0	113	728	1,098	0	192.01
192.02	19202	VACANT SPACE	0	0	0	0	0	192.02
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)	498,611	1,054,318	1,471,576	760,616	1,988,731	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	77.400031	95.155054	16.554651	0.578922	0.372259	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	68,758	145,200	96,662	105,328	77,223	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	10.673393	13.104693	1.087409	0.080168	0.014455	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: 15-1311 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I | Date/Time Prepared: 5/29/2024 2:28 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs: Total Costs	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	5,659,780		5,659,780	0	0	30.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	5,408,456		5,408,456	0	0	50.00
53.00	05300	ANESTHESIOLOGY	99,717		99,717	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,161,374		3,161,374	0	0	54.00
60.00	06000	LABORATORY	2,702,664		2,702,664	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,179,907	0	1,179,907	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,516,439	0	1,516,439	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	459,793	0	459,793	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	75,177	0	75,177	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,213,682		1,213,682	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	451,920		451,920	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,161,135		1,161,135	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,631,198		6,631,198	0	0	73.00
73.01	03480	ONCOLOGY	520,687		520,687	0	0	73.01
73.02	07301	BLOOD DISORDER DRUGS	1,735,605		1,735,605	0	0	73.02
76.00	03160	CARDIOPULMONARY	0		0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	584,268		584,268	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							
91.00	09100	EMERGENCY	5,495,317		5,495,317	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	809,065		809,065		0	92.00
	OTHER REIMBURSABLE COST CENTERS							
102.00	10200	OPIOID TREATMENT PROGRAM	0		0		0	102.00
200.00		Subtotal (see instructions)	38,866,184	0	38,866,184	0	0	200.00
201.00		Less Observation Beds	809,065		809,065		0	201.00
202.00		Total (see instructions)	38,057,119	0	38,057,119	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES	Provider CCN: 15-1311	Period: From 01/01/2023 To 12/31/2023	Worksheet C Part I Date/Time Prepared: 5/29/2024 2:28 pm
	Title XVIII	Hospital	Cost

		Cost Center Description	Charges Inpatient	Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	5,736,037		5,736,037			30.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,021,705	24,253,482	25,275,187	0.213983	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	46,332	1,737,463	1,783,795	0.055902	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	498,610	12,651,605	13,150,215	0.240405	0.000000	54.00
60.00	06000	LABORATORY	889,559	6,903,875	7,793,434	0.346787	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	653,605	1,428,694	2,082,299	0.566637	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	512,257	2,808,887	3,321,144	0.456601	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	265,646	699,335	964,981	0.476479	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	49,130	82,746	131,876	0.570058	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	459,367	5,594,343	6,053,710	0.200486	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	127,460	2,098,759	2,226,219	0.202999	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,214,235	7,889,554	9,103,789	0.127544	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,648,051	20,849,075	22,497,126	0.294758	0.000000	73.00
73.01	03480	ONCOLOGY	482	2,972,579	2,973,061	0.175135	0.000000	73.01
73.02	07301	BLOOD DISORDER DRUGS	0	9,599,721	9,599,721	0.180797	0.000000	73.02
76.00	03160	CARDIOPULMONARY	0	0	0	0.000000	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	794,751	794,751	0.735159	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							
91.00	09100	EMERGENCY	301,651	16,693,610	16,995,261	0.323344	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,974	1,877,931	1,879,905	0.430375	0.000000	92.00
	OTHER REIMBURSABLE COST CENTERS							
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0			102.00
200.00		Subtotal (see instructions)	13,426,101	118,936,410	132,362,511			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	13,426,101	118,936,410	132,362,511			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-1311 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I | Date/Time Prepared: 5/29/2024 2:28 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
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
60.00	06000	LABORATORY	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	73.00
73.01	03480	ONCOLOGY	0.000000	73.01
73.02	07301	BLOOD DISORDER DRUGS	0.000000	73.02
76.00	03160	CARDIOPULMONARY	0.000000	76.00
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		
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS		
102.00	10200	OPIOID TREATMENT PROGRAM		102.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-1311 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I | Date/Time Prepared: 5/29/2024 2:28 pm

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,659,780		5,659,780	0	5,659,780	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,408,456		5,408,456	0	5,408,456	50.00
53.00	05300	ANESTHESIOLOGY	99,717		99,717	0	99,717	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,161,374		3,161,374	0	3,161,374	54.00
60.00	06000	LABORATORY	2,702,664		2,702,664	0	2,702,664	60.00
65.00	06500	RESPIRATORY THERAPY	1,179,907	0	1,179,907	0	1,179,907	65.00
66.00	06600	PHYSICAL THERAPY	1,516,439	0	1,516,439	0	1,516,439	66.00
67.00	06700	OCCUPATIONAL THERAPY	459,793	0	459,793	0	459,793	67.00
68.00	06800	SPEECH PATHOLOGY	75,177	0	75,177	0	75,177	68.00
69.00	06900	ELECTROCARDIOLOGY	1,213,682		1,213,682	0	1,213,682	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	451,920		451,920	0	451,920	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,161,135		1,161,135	0	1,161,135	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,631,198		6,631,198	0	6,631,198	73.00
73.01	03480	ONCOLOGY	520,687		520,687	0	520,687	73.01
73.02	07301	BLOOD DISORDER DRUGS	1,735,605		1,735,605	0	1,735,605	73.02
76.00	03160	CARDIOPULMONARY	0		0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	584,268		584,268	0	584,268	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						
91.00	09100	EMERGENCY	5,495,317		5,495,317	0	5,495,317	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	809,065		809,065		809,065	92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0		0		0	102.00
200.00		Subtotal (see instructions)	38,866,184	0	38,866,184	0	38,866,184	200.00
201.00		Less Observation Beds	809,065		809,065		809,065	201.00
202.00		Total (see instructions)	38,057,119	0	38,057,119	0	38,057,119	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-1311 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I | Date/Time Prepared: 5/29/2024 2:28 pm

Title XIX | Hospital | PPS

		Cost Center Description	Charges Inpatient	Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,736,037		5,736,037			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,021,705	24,253,482	25,275,187	0.213983	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	46,332	1,737,463	1,783,795	0.055902	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	498,610	12,651,605	13,150,215	0.240405	0.000000	54.00
60.00	06000	LABORATORY	889,559	6,903,875	7,793,434	0.346787	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	653,605	1,428,694	2,082,299	0.566637	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	512,257	2,808,887	3,321,144	0.456601	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	265,646	699,335	964,981	0.476479	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	49,130	82,746	131,876	0.570058	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	459,367	5,594,343	6,053,710	0.200486	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	127,460	2,098,759	2,226,219	0.202999	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,214,235	7,889,554	9,103,789	0.127544	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,648,051	20,849,075	22,497,126	0.294758	0.000000	73.00
73.01	03480	ONCOLOGY	482	2,972,579	2,973,061	0.175135	0.000000	73.01
73.02	07301	BLOOD DISORDER DRUGS	0	9,599,721	9,599,721	0.180797	0.000000	73.02
76.00	03160	CARDIOPULMONARY	0	0	0	0.000000	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	794,751	794,751	0.735159	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						
91.00	09100	EMERGENCY	301,651	16,693,610	16,995,261	0.323344	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,974	1,877,931	1,879,905	0.430375	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0			102.00
200.00		Subtotal (see instructions)	13,426,101	118,936,410	132,362,511			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	13,426,101	118,936,410	132,362,511			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-1311 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I | Date/Time Prepared: 5/29/2024 2:28 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
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.213983	50.00
53.00	05300	ANESTHESIOLOGY	0.055902	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.240405	54.00
60.00	06000	LABORATORY	0.346787	60.00
65.00	06500	RESPIRATORY THERAPY	0.566637	65.00
66.00	06600	PHYSICAL THERAPY	0.456601	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.476479	67.00
68.00	06800	SPEECH PATHOLOGY	0.570058	68.00
69.00	06900	ELECTROCARDIOLOGY	0.200486	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.202999	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.127544	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.294758	73.00
73.01	03480	ONCOLOGY	0.175135	73.01
73.02	07301	BLOOD DISORDER DRUGS	0.180797	73.02
76.00	03160	CARDIOPULMONARY	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0.735159	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		
91.00	09100	EMERGENCY	0.323344	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.430375	92.00
		OTHER REIMBURSABLE COST CENTERS		
102.00	10200	OPIOID TREATMENT PROGRAM		102.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

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

Provider CCN: 15-1311 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part II | Date/Time Prepared: 5/29/2024 2:28 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	5,408,456	676,970	4,731,486	0	0	50.00
53.00	05300	ANESTHESIOLOGY	99,717	11,671	88,046	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,161,374	341,969	2,819,405	0	0	54.00
60.00	06000	LABORATORY	2,702,664	153,828	2,548,836	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,179,907	25,771	1,154,136	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,516,439	113,658	1,402,781	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	459,793	31,645	428,148	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	75,177	2,313	72,864	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,213,682	98,086	1,115,596	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	451,920	21,838	430,082	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,161,135	56,106	1,105,029	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,631,198	88,102	6,543,096	0	0	73.00
73.01	03480	ONCOLOGY	520,687	59,001	461,686	0	0	73.01
73.02	07301	BLOOD DISORDER DRUGS	1,735,605	23,059	1,712,546	0	0	73.02
76.00	03160	CARDIOPULMONARY	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	584,268	92,706	491,562	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						
91.00	09100	EMERGENCY	5,495,317	415,851	5,079,466	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	809,065	115,742	693,323	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
200.00		Subtotal (sum of lines 50 thru 199)	33,206,404	2,328,316	30,878,088	0	0	200.00
201.00		Less Observation Beds	809,065	115,742	693,323	0	0	201.00
202.00		Total (line 200 minus line 201)	32,397,339	2,212,574	30,184,765	0	0	202.00

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

Provider CCN: 15-1311 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part II | Date/Time Prepared: 5/29/2024 2:28 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	5,408,456	25,275,187	0.213983	50.00
53.00	05300	ANESTHESIOLOGY	99,717	1,783,795	0.055902	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,161,374	13,150,215	0.240405	54.00
60.00	06000	LABORATORY	2,702,664	7,793,434	0.346787	60.00
65.00	06500	RESPIRATORY THERAPY	1,179,907	2,082,299	0.566637	65.00
66.00	06600	PHYSICAL THERAPY	1,516,439	3,321,144	0.456601	66.00
67.00	06700	OCCUPATIONAL THERAPY	459,793	964,981	0.476479	67.00
68.00	06800	SPEECH PATHOLOGY	75,177	131,876	0.570058	68.00
69.00	06900	ELECTROCARDIOLOGY	1,213,682	6,053,710	0.200486	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	451,920	2,226,219	0.202999	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,161,135	9,103,789	0.127544	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,631,198	22,497,126	0.294758	73.00
73.01	03480	ONCOLOGY	520,687	2,973,061	0.175135	73.01
73.02	07301	BLOOD DISORDER DRUGS	1,735,605	9,599,721	0.180797	73.02
76.00	03160	CARDIOPULMONARY	0	0	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	584,268	794,751	0.735159	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				
91.00	09100	EMERGENCY	5,495,317	16,995,261	0.323344	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	809,065	1,879,905	0.430375	92.00
		OTHER REIMBURSABLE COST CENTERS				
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0.000000	102.00
200.00		Subtotal (sum of lines 50 thru 199)	33,206,404	126,626,474		200.00
201.00		Less Observation Beds	809,065	0		201.00
202.00		Total (line 200 minus line 201)	32,397,339	126,626,474		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-1311 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part II Date/Time Prepared: 5/29/2024 2:28 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	676,970	25,275,187	0.026784	469,465	12,574	50.00
53.00	05300	ANESTHESIOLOGY	11,671	1,783,795	0.006543	21,075	138	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	341,969	13,150,215	0.026005	203,280	5,286	54.00
60.00	06000	LABORATORY	153,828	7,793,434	0.019738	410,109	8,095	60.00
65.00	06500	RESPIRATORY THERAPY	25,771	2,082,299	0.012376	304,768	3,772	65.00
66.00	06600	PHYSICAL THERAPY	113,658	3,321,144	0.034223	243,576	8,336	66.00
67.00	06700	OCCUPATIONAL THERAPY	31,645	964,981	0.032793	129,665	4,252	67.00
68.00	06800	SPEECH PATHOLOGY	2,313	131,876	0.017539	25,768	452	68.00
69.00	06900	ELECTROCARDIOLOGY	98,086	6,053,710	0.016203	198,055	3,209	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	21,838	2,226,219	0.009809	64,002	628	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	56,106	9,103,789	0.006163	599,430	3,694	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	88,102	22,497,126	0.003916	773,762	3,030	73.00
73.01	03480	ONCOLOGY	59,001	2,973,061	0.019845	0	0	73.01
73.02	07301	BLOOD DISORDER DRUGS	23,059	9,599,721	0.002402	0	0	73.02
76.00	03160	CARDIOPULMONARY	0	0	0.000000	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	92,706	794,751	0.116648	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						
91.00	09100	EMERGENCY	415,851	16,995,261	0.024469	9,590	235	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	115,742	1,879,905	0.061568	0	0	92.00
200.00		Total (lines 50 through 199)	2,328,316	126,626,474		3,452,545	53,701	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1311 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV | Date/Time Prepared: 5/29/2024 2:28 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	03480	ONCOLOGY	0	0	0	0	0	73.01
73.02	07301	BLOOD DISORDER DRUGS	0	0	0	0	0	73.02
76.00	03160	CARDIOPULMONARY	0	0	0	0	0	76.00
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						
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1311 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV | Date/Time Prepared: 5/29/2024 2:28 pm

Title XVIII | Hospital | Cost

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	25,275,187	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	1,783,795	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	13,150,215	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	7,793,434	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	2,082,299	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	3,321,144	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	964,981	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	131,876	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	6,053,710	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	2,226,219	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	9,103,789	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	22,497,126	0.000000	73.00
73.01	03480	ONCOLOGY	0	0	0	2,973,061	0.000000	73.01
73.02	07301	BLOOD DISORDER DRUGS	0	0	0	9,599,721	0.000000	73.02
76.00	03160	CARDIOPULMONARY	0	0	0	0	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	794,751	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						
91.00	09100	EMERGENCY	0	0	0	16,995,261	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	1,879,905	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	126,626,474		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1311 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV | Date/Time Prepared: 5/29/2024 2:28 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	469,465	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	21,075	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	203,280	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	410,109	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	304,768	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	243,576	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	129,665	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	25,768	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	198,055	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	64,002	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	599,430	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	773,762	0	0	0	73.00
73.01	03480	ONCOLOGY	0.000000	0	0	0	0	73.01
73.02	07301	BLOOD DISORDER DRUGS	0.000000	0	0	0	0	73.02
76.00	03160	CARDIOPULMONARY	0.000000	0	0	0	0	76.00
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						
91.00	09100	EMERGENCY	0.000000	9,590	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		3,452,545	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1311 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part V Date/Time Prepared: 5/29/2024 2:28 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	0.213983	0	3,598,809	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.055902	0	123,183	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.240405	0	2,873,860	0	0	54.00
60.00	06000	LABORATORY	0.346787	0	1,347,437	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.566637	0	346,268	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.456601	0	905,021	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.476479	0	190,224	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.570058	0	15,314	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.200486	0	1,567,467	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.202999	0	477,023	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.127544	0	2,685,445	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.294758	0	8,699,483	140	0	73.00
73.01	03480	ONCOLOGY	0.175135	0	1,348,177	0	0	73.01
73.02	07301	BLOOD DISORDER DRUGS	0.180797	0	0	0	0	73.02
76.00	03160	CARDIOPULMONARY	0.000000	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.735159	0	296,238	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						
91.00	09100	EMERGENCY	0.323344	0	3,288,089	1,030	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.430375	0	238,395	0	0	92.00
200.00		Subtotal (see instructions)		0	28,000,433	1,170	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	28,000,433	1,170	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1311 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part V Date/Time Prepared: 5/29/2024 2:28 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Costs		
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	770,084	0	50.00
53.00	05300	ANESTHESIOLOGY	6,886	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	690,890	0	54.00
60.00	06000	LABORATORY	467,274	0	60.00
65.00	06500	RESPIRATORY THERAPY	196,208	0	65.00
66.00	06600	PHYSICAL THERAPY	413,233	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	90,638	0	67.00
68.00	06800	SPEECH PATHOLOGY	8,730	0	68.00
69.00	06900	ELECTROCARDIOLOGY	314,255	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	96,835	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	342,512	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,564,242	41	73.00
73.01	03480	ONCOLOGY	236,113	0	73.01
73.02	07301	BLOOD DISORDER DRUGS	0	0	73.02
76.00	03160	CARDIOPULMONARY	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	217,782	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			
91.00	09100	EMERGENCY	1,063,184	333	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	102,599	0	92.00
200.00		Subtotal (see instructions)	7,581,465	374	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	7,581,465	374	202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS	Provider CCN: 15-1311	Period: From 01/01/2023 To 12/31/2023	Worksheet D Part I Date/Time Prepared: 5/29/2024 2:28 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	809,666	46,342	763,324	1,873	407.54	30.00
200.00	Total (lines 30 through 199)	809,666		763,324	1,873		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	8	3,260	30.00
200.00	Total (lines 30 through 199)	8	3,260	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 15-1311 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part II | Date/Time Prepared: 5/29/2024 2:28 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	676,970	25,275,187	0.026784	0	0	50.00
53.00	05300	ANESTHESIOLOGY	11,671	1,783,795	0.006543	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	341,969	13,150,215	0.026005	566	15	54.00
60.00	06000	LABORATORY	153,828	7,793,434	0.019738	5,034	99	60.00
65.00	06500	RESPIRATORY THERAPY	25,771	2,082,299	0.012376	7,224	89	65.00
66.00	06600	PHYSICAL THERAPY	113,658	3,321,144	0.034223	1,227	42	66.00
67.00	06700	OCCUPATIONAL THERAPY	31,645	964,981	0.032793	630	21	67.00
68.00	06800	SPEECH PATHOLOGY	2,313	131,876	0.017539	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	98,086	6,053,710	0.016203	256	4	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	21,838	2,226,219	0.009809	329	3	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	56,106	9,103,789	0.006163	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	88,102	22,497,126	0.003916	25,369	99	73.00
73.01	03480	ONCOLOGY	59,001	2,973,061	0.019845	482	10	73.01
73.02	07301	BLOOD DISORDER DRUGS	23,059	9,599,721	0.002402	0	0	73.02
76.00	03160	CARDIOPULMONARY	0	0	0.000000	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	92,706	794,751	0.116648	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						
91.00	09100	EMERGENCY	415,851	16,995,261	0.024469	6,052	148	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	115,742	1,879,905	0.061568	0	0	92.00
200.00		Total (lines 50 through 199)	2,328,316	126,626,474		47,169	530	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1311 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part III | Date/Time Prepared: 5/29/2024 2:28 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
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	1,873	0.00	8	30.00
200.00		Total (lines 30 through 199)		0	1,873		8	200.00

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

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1311 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV | Date/Time Prepared: 5/29/2024 2:28 pm

Title XIX | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	03480	ONCOLOGY	0	0	0	0	0	73.01
73.02	07301	BLOOD DISORDER DRUGS	0	0	0	0	0	73.02
76.00	03160	CARDIOPULMONARY	0	0	0	0	0	76.00
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						
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1311 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV | Date/Time Prepared: 5/29/2024 2:28 pm

Title XIX | Hospital | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	25,275,187	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	1,783,795	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	13,150,215	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	7,793,434	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	2,082,299	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	3,321,144	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	964,981	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	131,876	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	6,053,710	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	2,226,219	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	9,103,789	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	22,497,126	0.000000	73.00
73.01	03480	ONCOLOGY	0	0	0	2,973,061	0.000000	73.01
73.02	07301	BLOOD DISORDER DRUGS	0	0	0	9,599,721	0.000000	73.02
76.00	03160	CARDIOPULMONARY	0	0	0	0	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	794,751	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						
91.00	09100	EMERGENCY	0	0	0	16,995,261	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	1,879,905	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	126,626,474		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1311 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV | Date/Time Prepared: 5/29/2024 2:28 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
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	566	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	5,034	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	7,224	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	1,227	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	630	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	256	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	329	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	25,369	0	0	0	73.00
73.01	03480	ONCOLOGY	0.000000	482	0	0	0	73.01
73.02	07301	BLOOD DISORDER DRUGS	0.000000	0	0	0	0	73.02
76.00	03160	CARDIOPULMONARY	0.000000	0	0	0	0	76.00
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						
91.00	09100	EMERGENCY	0.000000	6,052	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		47,169	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1311 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part V Date/Time Prepared: 5/29/2024 2:28 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	0.213983	0	959,747	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.055902	0	119,345	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.240405	0	81,269	0	0	54.00
60.00	06000	LABORATORY	0.346787	0	42,685	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.566637	0	837	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.456601	0	24,849	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.476479	0	315	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.570058	0	636	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.200486	0	26,569	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.202999	0	10,003	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.127544	0	26,095	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.294758	0	745,437	0	0	73.00
73.01	03480	ONCOLOGY	0.175135	0	58,426	0	0	73.01
73.02	07301	BLOOD DISORDER DRUGS	0.180797	0	0	0	0	73.02
76.00	03160	CARDIOPULMONARY	0.000000	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.735159	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						
91.00	09100	EMERGENCY	0.323344	0	148,302	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.430375	0	0	0	0	92.00
200.00		Subtotal (see instructions)		0	2,244,515	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	2,244,515	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1311 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part V Date/Time Prepared: 5/29/2024 2:28 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	205,370	0	50.00
53.00	05300	ANESTHESIOLOGY	6,672	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	19,537	0	54.00
60.00	06000	LABORATORY	14,803	0	60.00
65.00	06500	RESPIRATORY THERAPY	474	0	65.00
66.00	06600	PHYSICAL THERAPY	11,346	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	150	0	67.00
68.00	06800	SPEECH PATHOLOGY	363	0	68.00
69.00	06900	ELECTROCARDIOLOGY	5,327	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,031	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,328	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	219,724	0	73.00
73.01	03480	ONCOLOGY	10,232	0	73.01
73.02	07301	BLOOD DISORDER DRUGS	0	0	73.02
76.00	03160	CARDIOPULMONARY	0	0	76.00
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			
91.00	09100	EMERGENCY	47,953	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
200.00		Subtotal (see instructions)	547,310	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	547,310	0	202.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-1311	Period: From 01/01/2023 To 12/31/2023	Worksheet D-1 Date/Time Prepared: 5/29/2024 2:28 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)	2,013	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,873	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)	1,589	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	111	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	29	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)	850	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)	111	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)	5,659,780	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)	7,723	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)	323,942	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	5,335,838	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)	5,335,838	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)	2,848.82	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,421,497	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)	2,421,497	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1311 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/29/2024 2:28 pm

Title XVIII | Hospital | Cost

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	1,013,435	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)	3,434,932	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)	316,219	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	316,219	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)	284	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	2,848.82	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	809,065	89.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-1311	Period: From 01/01/2023 To 12/31/2023	Worksheet D-1 Date/Time Prepared: 5/29/2024 2:28 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	809,666	5,659,780	0.143056	809,065	115,742	90.00
91.00	Nursing Program cost	0	5,659,780	0.000000	809,065	0	91.00
92.00	Allied health cost	0	5,659,780	0.000000	809,065	0	92.00
93.00	All other Medical Education	0	5,659,780	0.000000	809,065	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-1311	Period: From 01/01/2023 To 12/31/2023	Worksheet D-1 Date/Time Prepared: 5/29/2024 2:28 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)	2,013	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,873	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)	1,589	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	111	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	29	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)	8	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	266.32	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	5,659,780	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)	7,723	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)	323,942	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	5,335,838	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)	5,335,838	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)	2,848.82	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	22,791	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)	22,791	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1311 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/29/2024 2:28 pm

Title XIX | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						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)	16,472	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)	39,263	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)	3,260	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	530	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	3,790	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	35,473	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)	284	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	2,848.82	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	809,065	89.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-1311	Period: From 01/01/2023 To 12/31/2023	Worksheet D-1 Date/Time Prepared: 5/29/2024 2:28 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	809,666	5,659,780	0.143056	809,065	115,742	90.00
91.00	Nursing Program cost	0	5,659,780	0.000000	809,065	0	91.00
92.00	Allied health cost	0	5,659,780	0.000000	809,065	0	92.00
93.00	All other Medical Education	0	5,659,780	0.000000	809,065	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1311 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-3 | Date/Time Prepared: 5/29/2024 2:28 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		2,808,642		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.213983	469,465	100,458	50.00
53.00	05300	ANESTHESIOLOGY	0.055902	21,075	1,178	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.240405	203,280	48,870	54.00
60.00	06000	LABORATORY	0.346787	410,109	142,220	60.00
65.00	06500	RESPIRATORY THERAPY	0.566637	304,768	172,693	65.00
66.00	06600	PHYSICAL THERAPY	0.456601	243,576	111,217	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.476479	129,665	61,783	67.00
68.00	06800	SPEECH PATHOLOGY	0.570058	25,768	14,689	68.00
69.00	06900	ELECTROCARDIOLOGY	0.200486	198,055	39,707	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.202999	64,002	12,992	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.127544	599,430	76,454	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.294758	773,762	228,073	73.00
73.01	03480	ONCOLOGY	0.175135	0	0	73.01
73.02	07301	BLOOD DISORDER DRUGS	0.180797	0	0	73.02
76.00	03160	CARDIOPULMONARY	0.000000	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.735159	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				
91.00	09100	EMERGENCY	0.323344	9,590	3,101	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.430375	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		3,452,545	1,013,435	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)		3,452,545		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-1311 | Component CCN: 15-Z311 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-3 | Date/Time Prepared: 5/29/2024 2:28 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
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.213983	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.055902	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.240405	4,861	1,169	54.00
60.00	06000	LABORATORY	0.346787	20,097	6,969	60.00
65.00	06500	RESPIRATORY THERAPY	0.566637	21,928	12,425	65.00
66.00	06600	PHYSICAL THERAPY	0.456601	70,896	32,371	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.476479	39,211	18,683	67.00
68.00	06800	SPEECH PATHOLOGY	0.570058	2,904	1,655	68.00
69.00	06900	ELECTROCARDIOLOGY	0.200486	3,347	671	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.202999	329	67	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.127544	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.294758	49,862	14,697	73.00
73.01	03480	ONCOLOGY	0.175135	0	0	73.01
73.02	07301	BLOOD DISORDER DRUGS	0.180797	0	0	73.02
76.00	03160	CARDIOPULMONARY	0.000000	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.735159	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				
91.00	09100	EMERGENCY	0.323344	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.430375	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		213,435	88,707	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)		213,435		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1311 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-3 | Date/Time Prepared: 5/29/2024 2:28 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		26,918		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.213983	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.055902	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.240405	566	136	54.00
60.00	06000	LABORATORY	0.346787	5,034	1,746	60.00
65.00	06500	RESPIRATORY THERAPY	0.566637	7,224	4,093	65.00
66.00	06600	PHYSICAL THERAPY	0.456601	1,227	560	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.476479	630	300	67.00
68.00	06800	SPEECH PATHOLOGY	0.570058	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.200486	256	51	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.202999	329	67	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.127544	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.294758	25,369	7,478	73.00
73.01	03480	ONCOLOGY	0.175135	482	84	73.01
73.02	07301	BLOOD DISORDER DRUGS	0.180797	0	0	73.02
76.00	03160	CARDIOPULMONARY	0.000000	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.735159	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				
91.00	09100	EMERGENCY	0.323344	6,052	1,957	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.430375	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		47,169	16,472	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)		47,169		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1311	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part B Date/Time Prepared: 5/29/2024 2:28 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	7,581,839	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)	7,581,839	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)	7,657,657	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)	37,773	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	5,236,122	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)	2,383,762	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)	2,383,762	30.00
31.00	Primary payer payments	804	31.00
32.00	Subtotal (line 30 minus line 31)	2,382,958	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)	815,028	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	529,768	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	668,514	36.00
37.00	Subtotal (see instructions)	2,912,726	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)	2,912,726	40.00
40.01	Sequestration adjustment (see instructions)	58,255	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	2,768,751	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)	85,720	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	450,434	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: 15-1311	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part B Date/Time Prepared: 5/29/2024 2:28 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: 15-1311	Period: From 01/01/2023 To 12/31/2023	Worksheet E-1 Part I Date/Time Prepared: 5/29/2024 2:28 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		3,134,554		2,606,451	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	09/15/2023	162,300	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		162,300	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)		3,134,554		2,768,751	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		8,121		85,720	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		3,142,675		2,854,471	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: 15-1311 Component CCN: 15-Z311	Period: From 01/01/2023 To 12/31/2023	Worksheet E-1 Part I Date/Time Prepared: 5/29/2024 2:28 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		335,885		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)		335,885		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		64,126		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		400,011		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: 15-1311	Period: From 01/01/2023 To 12/31/2023	Worksheet E-1 Part II Date/Time Prepared: 5/29/2024 2:28 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: 15-1311 | Component CCN: 15-Z311 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E-2 | Date/Time Prepared: 5/29/2024 2:28 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)	319,381	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)	89,594	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	111	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)	408,975	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	408,975	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)	408,975	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	800	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (see instructions)	408,175	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)	408,175	0	19.00
19.01	Sequestration adjustment (see instructions)	8,164	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	335,885	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)	64,126	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	23,832	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: 15-1311 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E-3 Part V Date/Time Prepared: 5/29/2024 2:28 pm

Title XVIII | Hospital | Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	3,434,932	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)	3,434,932	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	3,469,281	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)	3,469,281	19.00
20.00	Deductibles (exclude professional component)	278,224	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	3,191,057	22.00
23.00	Coinsurance	800	23.00
24.00	Subtotal (line 22 minus line 23)	3,190,257	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	25,468	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	16,554	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	18,836	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	3,206,811	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)	3,206,811	30.00
30.01	Sequestration adjustment (see instructions)	64,136	30.01
30.02	Demonstration payment adjustment amount after sequestration	0	30.02
30.03	Sequestration adjustment-PARHM		30.03
31.00	Interim payments	3,134,554	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)	8,121	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	270,367	34.00

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

Provider CCN: 15-1311 | Period: From 01/01/2023 To 12/31/2023 | Worksheet G | Date/Time Prepared: 5/29/2024 2:28 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	47,247,624	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	4,743,281	0	0	0	4.00
5.00	Other receivable	340,139	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	1,055,753	0	0	0	7.00
8.00	Prepaid expenses	67,723	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)	53,454,520	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	0	0	0	0	15.00
16.00	Accumulated depreciation	0	0	0	0	16.00
17.00	Leasehold improvements	3,139,179	0	0	0	17.00
18.00	Accumulated depreciation	-1,964,119	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	2,738	0	0	0	21.00
22.00	Accumulated depreciation	-2,738	0	0	0	22.00
23.00	Major movable equipment	15,517,447	0	0	0	23.00
24.00	Accumulated depreciation	-11,576,832	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)	5,115,675	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	28,407,117	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	28,407,117	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	86,977,312	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	3,297,162	0	0	0	37.00
38.00	Salaries, wages, and fees payable	781,874	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	3,220,303	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	7,299,339	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	9,655,000	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	169,566	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	9,824,566	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	17,123,905	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	69,853,407				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)	69,853,407	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	86,977,312	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-1311 | Period: From 01/01/2023 To 12/31/2023 | Worksheet G-1 | Date/Time Prepared: 5/29/2024 2:28 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		64,877,773		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		2,576,007				2.00
3.00	Total (sum of line 1 and line 2)		67,453,780		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00	TEMP RESTRICTED	2,399,628		0		0	5.00
6.00		0		0		0	6.00
7.00	ROUNDING	-1		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)		2,399,627		0		10.00
11.00	Subtotal (line 3 plus line 10)		69,853,407		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)		69,853,407		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	TEMP RESTRICTED		0		5.00
6.00			0		6.00
7.00	ROUNDING		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: 15-1311 | Period: From 01/01/2023 To 12/31/2023 | Worksheet G-2 Parts I & II Date/Time Prepared: 5/29/2024 2:28 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	5,587,381		5,587,381	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	148,656		148,656	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)	5,736,037		5,736,037	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	5,736,037		5,736,037	17.00
18.00	Ancillary services	7,386,439	100,364,869	107,751,308	18.00
19.00	Outpatient services	303,625	18,571,541	18,875,166	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	NONALLOWABLE REVENUE	0	74,805	74,805	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	13,426,101	119,011,215	132,437,316	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		42,369,036		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)		42,369,036		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 15-1311	Period: From 01/01/2023 To 12/31/2023	Worksheet G-3 Date/Time Prepared: 5/29/2024 2:28 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	132,437,316	1.00
2.00	Less contractual allowances and discounts on patients' accounts	91,014,235	2.00
3.00	Net patient revenues (line 1 minus line 2)	41,423,081	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	42,369,036	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-945,955	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	3,521,962	24.00
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (sum of lines 6-24)	3,521,962	25.00
26.00	Total (line 5 plus line 25)	2,576,007	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)	2,576,007	29.00